

**Barriers to access to safe abortion services:
Perspectives of potential clients of a hilly district of Nepal
(A mixed method study)**

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January 2007

gtz

**Study supported by
GTZ - Health Sector Support Programme
Kathmandu, Nepal**

Barriers to access to safe abortion services: Perspectives of potential clients of a hilly district of Nepal (A mixed method study)

**A thesis report submitted in partial fulfillment of
Master of Public Health (MPH) course**

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January 2007

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Acknowledgement

I would like to take the opportunity to express my sincere gratitude to all those who have in some way contributed to make my independent dissertation meaningful. In particular, I would like to thank all the respondents of my study who participated with all enthusiasm and allowed me to learn from their perspectives. Special gratitude also goes to my technical supervisors for this study, Sabina Faiz Rashid and Angelika Schrettenbrunner, for guiding and encouraging me throughout the study. I am indebted to James P Grant School of Public Health for granting me the opportunity to carry out this study independently. Further, I would like to extend my earnest gratefulness to many others who supported me at some phase of my study.

Thank you,

- Heidi Johnston (icddr,b), AMR Chowdhury (JPG SPH), Demissie Habte (JPG SPH), Shahaduz Zaman (JPG SPH), Muhammad Mizanur Rashid Shuvra (JPG SPH), Joan Vengaus (gtz/EPOS, Nepal), Cherry Bird (SSMP-Nepal), Kazi Mizanur Rahman (icddr.b), and Anand Tamang (CREHPA, Nepal) – for providing me insightful feedback and advice on my proposal;
- gtz – Health Sector Support Programme (HSSP), Nepal – for providing me financial and logistics support for the study;
- CREHPA, Nepal – for allowing me to draw on from your knowledge, attitude and perception survey questionnaire;
- Medical Superintendent, District Hospital Dhading – for allowing me to interview hospital staff and clients, and to review hospital records;
- District Health Office, Dhading – for necessary correspondence and coordination with the peripheral health facilities;
- Damar Ghimire (gtz/HSSP) – for facilitating the coordination with all necessary stakeholders in Dhading for field work;
- Team members of gtz-HSSP, Kathmandu – for extending cooperation in several ways to carry out this study in Nepal;

- Research Assistants, Sita Thapa and Kopila Loppa (Dhading) – for their hard-work and kind assistance in the field – collecting and transcribing data;
- Government health facility In-charge and involved FCHVs of the two villages – for their cooperation in selecting and bringing up the participants at short notice;
- My BRAC_MPH_2006 batch-mates – for being so wonderful and making me feel at home throughout the course, and their insightful feedbacks on my works;
- My parents for their encouragement and blessings;
- Last but not the least, my wife Samiksha – for helping me in data entry, and supporting me throughout; and my lovely little Munu (Akanksha) – for cheering me up always, and for disturbing me while working at home! (I really missed that for almost a year due to MPH course.)

Everyone's contribution is much appreciated!

AB

List of abbreviations and acronyms

ANM	Auxiliary Nurse Midwife
CAC	Comprehensive Abortion Care
CBS	Central Bureau of Statistics
CPR	Contraceptive Prevalence Rate
CREHPA	Centre for Research on Environment Health and Population Activities
D&C	Dilatation and Curettage
DHO	District Health Office
DoHS	Department of Health Services
EVA	Electric Vacuum Aspiration
FCHV	Female Community Health Volunteer
FGD	Focus Group Discussion
FHD	Family Health Division
FWCW	Fourth Women Conference on Women
FWLD	Forum for Women Law and Development
ICPD	International Conference on Population and Development
KAP	Knowledge, Attitude and Perception
JPGSPH	James P Grant School of Public Health
MMR	Maternal Mortality Ratio
MoHP	Ministry of Health and Population
MVA	Manual Vacuum Aspiration
MWRA	Married Women of Reproductive Age
NDHS	Nepal Demographic and Health Survey
NGO	Non Governmental Organization
PAC	Post Abortion Care
VDC	Village Development Committee
WHO	World Health Organization

Background

Unsafe abortion is a major public health problem in the world. Unsafe abortion accounts for 13% of approximately 67,000 maternal deaths every year. Nepal is a country with one of the highest maternal mortality ratios in the world. Nepal decriminalized and legalized abortion in September 2002 in a bid to reduce maternal mortality and morbidity. Even though it's liberal, safe abortion services are difficult to access. Few studies have been undertaken in Nepal in the post-legalization period to understand different aspects of legal and safe abortion services. This study was undertaken to explore the perspectives of potential clients of a hilly district of Nepal with an objective to assess the barriers to access legal and safe abortion services.

Methodology

The study was conducted in two villages of Dhading, a hilly/mountainous district of Nepal where safe abortion services are available only in the district hospital. The study was carried out with married women of reproductive age (MWRA), i.e. 15-49 years, the potential clients of safe abortion services. Mixed research methodology – with Qualitative method as a core, supplemented by a simultaneous quantitative method – was used. For the study, multiple qualitative research tools (in-depth interviews, focus group discussions and informal interviews) and quantitative tools (structured survey and review of hospital records) were used. Two villages (one nearby the district headquarter, and the other far-off) in the district were chosen purposively. Purposive sampling was used to select the participants for qualitative tools too. FGDs were carried out with six groups (altogether 41 participants), in-depth interviews with 8 women, and informal interviews with 8 key informants. Qualitative data was analyzed manually. Systematic sampling was used for the survey, which was carried out with 72 respondents. Hospital records of safe abortion services from mid-April to mid-November 2006, which included 239 clients, were analyzed. Quantitative data were analyzed using SPSS 13.0 software. For survey,

descriptive as well as inferential statistics were used. Necessary steps were taken to ensure rights, anonymity and confidentiality of the participants.

Findings

Findings of FGDs and in-depth interviews are based on women's perception about socio-cultural views and other women's experience of abortion. They perceived that abortion was an issue characterized by stigma and shame in the communities. It was generally related to socially unacceptable relations and immoral behaviors; and the stigma was harsher for unmarried women. From religious point of view, many considered it a sin, which had repercussions across woman's several lives. Such beliefs were held mostly by the elderly section of population. However, many participants believed that the attitude of the society in general, and women in particular, was becoming more liberal.

The level of awareness regarding the liberalization of abortion and availability of safe services was low. The survey showed that only two-fifth of the respondents knew abortion was legal in Nepal (42%). In the FGDs, about half of 41 respondents had the legal awareness. The knowledge of legal and safe period of gestation for abortion was virtually non-existent in any respondent. Radio and peers were important source of information on abortion related awareness. Only about one third of survey respondents were aware of availability of abortion services in the district hospital. In FGDs, it was evident that fewer women from far-off village, as opposed to those of nearby one, were aware of this. Most of the women had positive view towards liberalization of abortion. Majority of the participants approved of abortion rights of women, including unmarried ones'. A survey finding showed that legal awareness has positive effect on attitude of women towards abortion rights of unmarried girls.

The perceptions of the participants in the FGDs and in-depth interviews, and hospital records pointed that abortion seeking was not much different across socio-demographic strata. However, among clients of the hospital the proportion of *dalit* (low caste Hindu group) was slightly lower. Completed family was the most common reason for seeking abortion. In the villages, 'medical' (local pharmacy/ clinic) or the peers were usually the

first contact points for abortion advice. Such 'medicals' either referred a woman to a listed or unlisted facility for abortion, or provided abortion services themselves. Fewer women from far-off villages went to district hospital for abortion services. They mostly received abortion services from local unqualified providers in the villages. Some women from the far-off site considered the services of the local providers to be safe. The costs of abortion by such unqualified providers in the villages seemed to be higher than that of hospital. But most women were unaware of the cost at hospital. After learning that the approximate cost of abortion service (including medicines) at hospital was around of Rs 1300 (US\$ 19), most mentioned that as reasonable. However, there were concerns that very poor women could not afford it. There were also concerns about the travel costs and family difficulties for going to district hospital to seek service.

Discussion

In the socio-cultural context in the villages, abortion remains an issue laden with attributes of immoral and irreligious behavior. It is not easily discussed and seeking abortion is usually a matter of secrecy, owing to the stigma and shame. The awareness about the liberalization of abortion in the country and the availability and cost of safe abortion services in one's own district is quite low. For the women of remote hilly villages, distance is a big influencing factor as it adds to the indirect, opportunity and familial costs. In addition to all these barriers, availability of unqualified providers in the villages has been crucial in women not being able to access safe and legal abortion services.

To ensure the accessibility to safe and legal abortion services, these barriers need to be addressed. Increasing the legal awareness, along with knowledge about availability of safe services and the permitted safe gestational limit for abortion, is vital. Availability of safe services can be expanded into remote settings by inclusion of mid-level providers and gradual introduction of medical abortion. Most importantly, the widespread services from unqualified providers should be discouraged through punitive measures.

1. INTRODUCTION

1.1 Background

International agreements and resolutions made in the International Conference on Population and Development (ICPD) in Cairo in 1994, and subsequent reiterations in the Fourth Women Conference on Women (FWCW) in Beijing in 1995 and Review and Appraisal of the Implementation of ICPD (ICPD+5) in New York in 1999, have affirmed the reproductive and sexual health as the human rights of women. In ICPD, Governments of the world recognized unsafe abortions as a major public health concern and recognized that, in circumstances where not against law, abortion should be safe and accessible [United Nations 1995, paragraph 8.25]. FWCW while affirming the agreements at ICPD went on further and called for Governments to “consider reviewing laws containing punitive measures against women who have undergone illegal abortions” and “to understand and better address the determinants and consequences of unsafe abortions” [United Nations 1996, paragraph 106]. Nepal is one of the countries that have ratified to these agreements.

The statistics related to unsafe abortions reflect the gravity of the problem. Every year, out of approximately 210 million pregnancies that occur worldwide, 80 million are unwanted and about 46 million (22% of the total) pregnancies end in induced abortion [Alan Guttmacher Institute 1999]. Out of these, about 20 million are done outside legal framework and are unsafe. Ninety-five percent of these occur in developing countries. The unsafe abortion rate for Asia is 13 per 1,000 women aged 15-44 years, and the ratio, 14 unsafe abortions to 100 live births [WHO 2004]. These unsafe abortions lead to approximately 67,000 maternal deaths every year, which makes up for 13% of total maternal deaths worldwide. In addition, other tens of thousand of women suffer considerable morbidity including infertility, following unsafe abortions [WHO 2003]. At present, almost all countries (98%) in the world have law that permits abortion to save the woman's life. However, only in little more than a third of the countries (40.5%) there is legal provision to allow abortion on request [Hyman AG and Castleman L 2005]. Even in some of these countries, the conditions and administrative requirements around abortion

and several other barriers hampers the free choice of women to seek safe abortion services. Nepal is one of such countries where the abortion law is relatively liberal but safe services are difficult to access.

1.2 Literature review

Nepal has one of the highest maternal mortality ratios (MMR) in the world at 539 maternal deaths per 100,000 live births [NDHS 2001]. Studies have hinted that the proportion of maternal mortality in Nepal due to abortion related complications is quite higher than the global or South-Asian average of around 13%. In a tertiary care hospital in the capital Kathmandu it was more than 50% [Thapa PJ et al 1992 in Ganatra B and Johnston HB 2002] and in another in eastern Nepal, 27% [Goswami A 2004]. Not just the mortality, morbidity burden due to abortions is also a big responsibility for hospitals in Nepal. Two hospital based studies showed that majority of the Obstetric and Gynecology admissions in the hospitals were due to abortion – 54% in one [MoH 1998], and from 20% to 60% in the other [CREHPA 1999]. In the backdrop of the international agreements recognizing the importance of women's reproductive rights; as a part of the governments' drive to reduce maternal mortality and morbidity; and following years of intensive evidence based research, advocacy and lobbying efforts of several national and international organizations and groups, Nepal legalized abortion in September 2002. But the safe abortion services (known as comprehensive abortion care or CAC¹) started in the country only in March 2004. Abortion is legal in Nepal on the following grounds:

1. Up to 12 weeks of gestation for any woman
2. Up to 18 weeks of gestation if pregnancy results from rape or incest
3. At any time during pregnancy, with advice of a medical practitioner or if the physical or mental health or life of a pregnant woman is at risk or if the fetus is deformed and incompatible with life

¹ CAC is the terminology used for safe induced abortion carried out at government approved (listed) health facilities by a trained provider. There is a separate administrative entity for post abortion care called PAC. Due to the effect of Mexico City Policy, the facilities, resources and records of PAC are not used for CAC services. Throughout this proposal, safe abortion services will be used to refer CAC services, unless mentioned otherwise.

Abortion is still punishable in two conditions – (i) sex selective abortion, and (ii) abortion without the consent of the pregnant woman [National Civil Code, 11th Amendment, 2002].

Currently, manual vacuum aspiration (MVA) is the only method being promoted for safe abortion services in Nepal for uterine gestation up to 12 weeks, and medical methods are not yet officially available. However, apart from MVA, the country's Safe Abortion Procedure 2006 has specified electric vacuum aspiration (EVA), pharmacological (medical) and dilatation and curettage (D&C) too in the list of abortion technologies to be adopted by a listed² service provider [FHD/MoHP, CREHPA and IPAS 2006]. As of May 30, 2006, government has listed 128 sites for providing safe abortion services (80 government and 48 private/NGO³ facilities), and 252 doctors (174 government and 78 private/NGO) and 196 nurses⁴ (133 government and 63 private/NGO) have been trained and listed. At present, 68 out of 75 districts have at least one approved site for the services. As of April 30, 2006, a total of 43,400 women have received safe abortion services, about three times higher from private/NGO facilities (73%) than from government ones (27%) [FHD/MoHP, 2006]. The statistics are encouraging, more so as a recent release of findings of *National Facility-based Abortion Baseline Survey 2006* (unpublished) shows that the number of beneficiaries of safe abortion services has reached around 59,000 [FHD/MoHP, CREHPA and IPAS 2006]. However, Nepal is in its initial stage of implementing Safe Abortion Program and considerable challenges exist to make the service access universal, mostly to those who need it the most, and reduce unsafe abortions to a minimum.

There is very little information about true rates of abortion in Nepal, even less for unsafe abortions [FHD/Ministry of Health (Nepal), CREHPA, FWLD, Ipas, PATH 2005]. But from some international figures and some national studies, it can be safely assumed that unsafe abortions are still abounding. Since the legalization of abortion, trends in the

² Listed provider or site refers to those approved by government to deliver abortion services. A listed provider may be working in unlisted site. In such case, the service is outside legal framework as quality of the facility is not endorsed by government.

³ Non Governmental Organization.

⁴ Nurses are trained as assistants. They are not yet approved as providers.

number of post abortion care (PAC) clients in hospitals showed a mixed trend, showing increase in some while decrease in others [FHD/MoHP, CREHPA & IPAS 2006]. Recent studies have shown that about 10-20% of the clients coming for PAC are due to complications of induced abortions [FHD/MoHP, CREHPA & WHO 2006, and FHD/MoHP, CREHPA & IPAS 2006]. These indicate the challenge of unsafe abortions still prevalent in magnitude similar to pre-legalization period. Even when services are available, wide gap in awareness is a major deterrent factor for access to any health services. The gap exists for legal and safe abortion services in Nepal. Only 49% of the urban men and women were aware of the legal status of abortion in 2006, four years after the liberalization [CREHPA 2006]. This is even poor for rural men and women. The level of awareness is even lower in rural population as another study has shown – only 20% of rural married women and 28% of men knew about the legalization of abortion [CREHPA/PPFA-International 2005]. Interestingly, most recent study showed that about half the women who received safe abortion services in different hospitals studied were not aware of the legal status of abortion [FHD/MoHP, CREHPA & IPAS 2006]. The correct knowledge of safe abortion service provider in one's district is also found to be disappointingly low. Recent study showed that only around half of the urban men and women were aware that safe abortion services were provided in their town/district (56%), and only a fifth of them correctly knew the health facility that provided the services [CREHPA 2006]. The education level also plays a role in determining the choice of the services. A study showed that majority of illiterate received abortion services from untrained providers as opposed to literates, more than four-fifth of who received services from trained provider [Tamang A 1996]. Apart from these, there are other factors too. As shown in the results of recent poll survey, majority of urban men and women agreed that negative attitude of society towards abortion (81%), high cost of services (73%), and long distance to the service providing facility (69%) were some of the main reasons for women to resort to clandestine, unsafe and illegal abortions [CREHPA 2006]. Anecdotal evidences and experience also show that, apart from information and education, physical, financial and socio-cultural factors play big role in determining the access to, and hence utilization of, safe abortion services. Even when health services of reasonable quality exist, many may not use them due to these factors [Ensor T & Cooper S 2004]. This is in

general about demand side factors for any health service, and is equally true for abortion services as well.

Being in an initial phase of implementation of safe abortion program, most of the attention of the state has been on ensuring the supply side – like training providers, preparing protocols and guidelines, and maintaining supplies. It's important to ensure adequate supply of services to increase access. "Yet while these interventions (reducing supply side barrier) are important, they do not address many of the barriers to accessing services faced by a patient in a low-income countries" [Ensor T & Cooper S 2004]. "Majority of the important reasons for not seeking care are found to be demand factors" [Barkat et al 1995 reported in Ensor T & Cooper S 2004]. Though this conclusion was based on clients of emergency obstetric care, it is relevant for any reproductive health service.

1.3 Rationale

Few studies have been undertaken on abortion⁵ in Nepal in the post-legalization period. There are mainly opinion polls, analysis of hospital records, and structured surveys assessing knowledge, attitude and perception; mostly done in urban areas (polls and hospital based studies) and few in rural areas of more accessible districts in Terai⁶ region. Studies trying to explore the perspectives of clientele have been limited mainly to structured surveys and opinion polls, and few focus group discussions (FGD) and in-depth interviews. In such context, it was thought that understanding in depth the barriers on client side to access and utilize services would be important to adequately inform the future course of action of safe abortion programs. So, this study was undertaken to explore the determinants around the clients that hampers the access to safe abortion services. The issue of barriers to access is not a new one, but this study aimed to serve

⁵ In this study, the focus was induced abortion. So, the term abortion used throughout this report is meant to be induced abortion, unless mentioned otherwise.

⁶ Nepal is topographically divided into three terrains – Terai (flat land of Gangetic plains), Hills (up to about 4,500 m above sea level) and Mountains (above 4,500 m above sea level). The geographical terrain becomes increasingly difficult from Terai to Hills to Mountains, and with it the access to roads, transportation and communication facilities become poorer.

minimizing the existing dearth of in-depth information particularly from the perspectives of married women of reproductive age group (MWRA) from hilly areas of Nepal.

1.4 Relevant Definitions

Abortion is the termination of a pregnancy before the fetus has attained viability, i.e. become capable of independent extra-uterine life [WHO 2003].

Induced abortion is the deliberate termination of a pregnancy before the fetus has attained viability, i.e. become capable of independent extra-uterine life [WHO 2003].

Unsafe abortion is the procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking minimal standards, or both [WHO 2003].

1.5 Objective

1.5.1 General Objective

To assess the barriers to access legal and safe abortion services from the perspectives of potential clients (MWRA) of a hilly district of Nepal

1.5.2 Specific Objectives

- To understand the key factors hindering utilization of government approved safe abortion services from the perspectives of potential clients
- To learn the knowledge, attitude, beliefs and perceptions related to legal and safe abortion services amongst potential clients
- To appreciate the perspectives of potential clients of abortion services on how to improve the quality of safe abortion services

2.1 Study Site

The study was conducted in Dhading, a hilly/mountainous district of Nepal that lies west to Kathmandu. In Dhading, safe abortion services are available in the district hospital located in the district headquarter, Dhadingbesi. The context of safe abortion services in the district is given in the findings section of this report. The study was conducted in two Village Development Committees (VDC⁷) – one adjacent to the district headquarter and one far from the district headquarter. For confidentiality the names of the VDC is not mentioned in the report. Throughout this report, the adjacent VDC will be referred to as “nearby site” and the other, “far-off site”. The nearby site borders the district headquarter and has around the year graveled road access to some parts. All the wards of this village are within three hours walking distance from the district headquarter. The far-off site is located towards north-west of the district headquarter at a distance of about 10 hours walk (approximately more than 20 km walking trail). Nearest road head (which is a rough road with very few public transports and is not functional during rainy season) is about three hours walk from this site.

2.2 Study Population

The study was carried out with married women of reproductive age (MWRA), i.e. 15-49 years, of the selected sites of the district. They have been taken as the potential clients of safe abortion services in this study. They were taken irrespective of the history of induced abortion or permanent sterilization. Unmarried females of reproductive age group were not considered in this study. This is because the topic of abortion is too sensitive to be discussed with unmarried girls in villages as the rural society in general in Nepal is conservative. Moreover, it would take lot of coordination and arrangements beforehand to arrange interviews with them which was not feasible in the short time frame of this study. Though the study population was MWRA, few informal interviews have been taken with some key informants, not necessarily MWRA.

⁷ VDC is an administrative division of district. Each VDC has 9 wards as smaller units.

2.3 Methods and Tools

In this study mixed research methodology was applied. Qualitative method was the core, which was supplemented with a simultaneous quantitative method. Quantitative part was used to supplement the findings mainly on the knowledge, attitude and perception aspects.

Multiple qualitative research tools were used in the study – in-depth interviews, focus group discussions (FGD), and informal interviews. For in-depth interviews and FGDs, separate sets of specific guiding questions were used. Apart from these main questions, further follow-up or probing questions were used on-the-spot depending upon the flow of responses. The sets of guiding questions are given in *Annex 1*.

In the quantitative part a cross-sectional survey and review of existing hospital records of safe abortion services were used. For the survey, a structured closed-ended questionnaire (given in *Annex 2*) to assess knowledge, attitude and perception related to safe and legal abortion services was developed – it was adapted from standard survey questionnaires developed by CREHPA (Center for Research on Environment Health and Population Activities), an NGO working on abortion issues in Nepal for several years. Verbal permission from the director of the NGO was taken beforehand for adapting the questionnaire. The questionnaire was developed in English and was translated to Nepali by the researcher. It was pre-tested in the district headquarter of Dhading, and some final changes were made based on that.

2.4 Sampling

Different sampling techniques were used for qualitative and quantitative methods. As mentioned above, two VDC were purposively chosen in a way that these were different based on the geographical access (distance and vehicular road access) from the district headquarter. Purposive sampling was done for qualitative method.

FGD It was carried out with six groups having altogether 41 respondents (average 7 MWRA per group) – two groups in the nearby site, and four in the far-off. The

participants were taken from few selective wards in both VDCs as per the suggestion of the In-charge of government health facility in the VDC. The participants were selected with the help of Female Community Health Volunteer (FCHV⁸) of the particular ward. To maintain the diversity, participants were taken from different age groups and different castes. To ensure easy interaction amongst the participants, homogeneity as regards to the age-group was tried to be maintained in four groups. Two FGD were carried with younger women (aged up to 25 years), two with women aged 26 to 45 years, and two with mixed age groups. Caste diversity was maintained in all groups, except one which had mostly Newar women. The diversity of the participants can be seen in *table 1* (given on *page 13*) showing their socio-demographic characteristics.

In-depth interview It was carried out with eight MWRA – four in each of the two sites. Five of the respondents were selected from the FGDs. These respondents were articulate and willing to talk further with the researcher. Of the remaining three, one was selected when she had come to health facility for a check-up for pregnancy. She agreed to talk to researcher for an hour in the health facility. Other two were selected on the recommendations of the FCHV (based on willingness to talk). Care was taken to have diverse age-group and castes among the respondents. The socio-demographic characteristics of these respondents are outlined in *table 1*.

Informal interview It was carried out with eight key informants. One of them was the safe abortion service counselor (designated as CAC counselor) of the district hospital. She had been recruited by a local NGO and had been working for about 2 years in that position. One was a client who came to the hospital for abortion service. Other two were pharmacy owners at two different sites in the district. One of the pharmacies had provisions for abortion services (not approved by government and not meeting the criteria for safe abortion) and the other referred clients to government listed as well as unlisted service providers, depending upon the period of gestation. For anonymity, the place these

⁸ FCHVs are volunteer cadre in the health system of Nepal. They have important mobilization role in many family, maternal and child health programs.

two pharmacies are located is not mentioned in this report. Remaining four were the FCHVs, who helped select the participants for FGDs and in-depth interviews.

Table 1: Socio-demographic characteristics of FGD and in-depth interview participants

FGD (n = 41)		In-depth (n = 8)	
Caste	Frequency	Caste	Frequency
Newar	16	Brahmin/Chhetri	3
Brahmin/Chhetri	14	Gurung/Magar	3
Kami/Damai/Sarki	6	Newar	1
Gurung/Magar	4	Kami/Damai/Sarki	1
Muslim	1		
Religion	Frequency	Religion	Frequency
Hindu	37	Hindu	8
Buddhist	3		
Muslim	1		
Age	Frequency	Age	Frequency
18-25	19	18-25	3
26-35	16	26-35	3
36-45	6	36-45	2
Education	Frequency	Education	Frequency
None	7	None	1
Informal	8	Informal	0
Primary	13	Primary	2
Secondary	9	Secondary	2
SLC and higher	4	SLC and higher	3
Occupation	Frequency	Occupation	Frequency
Housewife	18	Housewife	3
Agriculture	15	Shopkeeping	2
Shopkeeping	4	Social work	1
Social work	2	Seasonal labour	1
Seasonal labour	1	Retired teacher	1
Student	1		
# of children	Frequency	# of children	Frequency
0	4	0	1
1-2	21	1-2	3
3-5	16	3-5	4

Survey The sites were hilly area with scattered houses. The list of houses was not available. In each of the two sites, a relatively dense area with around 100 houses near the

government health facility was chosen with the help of the health facility In-charge. Then a systematic approach was taken to select the respondents (MWRA). In the selected area, every third house was selected and a MWRA present in the house was interviewed. If there were more than one MWRA in a house, then the youngest one was taken. If there was no eligible interviewee in the selected house, next house was taken. If no eligible interviewee was found in that house too, then the survey was to be marked as “non-response”. Since the houses were located in a haphazard manner in the hills and could not be numbered along one single trail, the research assistants taking the interview numbered the houses, as they went along, in a pragmatic way. Survey was conducted with a sample of 72⁹ respondents – 40 from the nearby site and 32 from the far-off.

Record review Records of safe abortion services at Dhading District Hospital of recent seven months, from mid-April to mid-November 2006, were taken. Before mid-April 2006, records were kept in a different format and were mixed with post abortion care (PAC) records. So they were not used.

2.5 Data Collection

The data was collected over a period of 2 weeks, from November 30 to December 14, 2006. The data collection was carried out by the researcher and two research assistants. The research assistants were two young females, one trained as auxiliary nurse midwife (ANM) and other as laboratory assistant. A day long training was given to both by the researcher on abortion issues and administration of survey questionnaire. Then they practiced interviewing (using the survey questionnaire) for next half day at the district headquarter, under the supervision of the researcher. These interviews were also used as a pretest of the questionnaire. Some changes were made in the questionnaire based on the pretest.

⁹ The required sample size was calculated using Epi Info (version 3.3.2) software. Using population size of 999,999 (infinite), confidence level of 95%, and expected frequency of 20% ($\pm 10\%$), the sample size came out to be 61. Allowing a possibility of at least 10% non-response, a size of 68 was required for this survey. Expected frequency was based on a recent survey which showed that 20% of the rural married women were aware of the legalization of abortion [CREHPA/PPFA 2005].

All qualitative part of the study was carried out by the main researcher. One research assistant was kept in all FGDs and in-depth interviews to take notes. It was done also to ensure the presence of a female to make the respondent feel comfortable talking about the sensitive issue (abortion) with the main researcher, a male. FGDs were carried out in the health facility or at FCHV's house, at a time suggested by the FCHV – ensuring that it was convenient for the participants, with minimal possible interference with their household chores or other works. Four FGDs were carried out in the afternoon and two in the morning. Average time for an FGD was about an hour. Some of the In-depth interviews were done immediately after FGD in the same venue, and few were done at or near the interviewee's house at a time agreed by them. Only one interview was conducted at a health facility, as the interviewee was a woman visiting to have a check-up for suspected pregnancy. Average time for an in-depth interview was about 45 minutes. Informal interviews with the pharmacy owners were done at their pharmacies and with the CAC counselor, at the hospital during office time. FCHVs were interviewed while they brought participants for FGD. A client in the hospital was interviewed while she was waiting for abortion service. It was brief and informal as she had to go in for abortion procedure short after the interview was started, and after the procedure she refused to talk. So, an in-depth interview could not be taken with her. She was the only client during the two days researcher waited for interviewing clients at the hospital.

The survey was carried out by the research assistants. Both quantitative and qualitative data collection were carried out simultaneously. Records of safe abortion services of the district hospital for seven months, as described above, were photocopied for analysis to be done later.

2.6 Data Transcription and Analysis

Qualitative data from FGD, in-depth and informal interviews was transcribed verbatim from the notes in Nepali by the research assistants within few days of collection. Transcription could not be carried out on the same day due to lack of facilities (like electricity) in the field. Translation into English was done by researcher after the period

of data collection. The data was then analyzed manually; it was coded into general and sub codes. Recurrent themes and patterns were identified and interpreted accordingly.

Quantitative data from survey and the hospital records were entered into and analyzed using SPSS 13.0 software. For survey, descriptive statistics were generated to analyze socio-demographic characteristics of the survey respondents. These statistics were also used to describe the distribution of knowledge, attitude and practice amongst the respondents of the survey. Cross-tabulation and Chi-square tests were run to analyze the association between – (i) the survey site (nearby and far-off) and the knowledge of respondents; (ii) the survey site and the preference of service provider; and (iii) knowledge and attitude of the respondents. For the hospital records, descriptive statistics were generated to see the socio-demographic distribution of the clients; reasons for seeking abortion; contraceptives provided after the procedure; and the service fee exemptions made.

2.7 Reporting

After analysis and interpretation, all the findings along with discussion have been compiled into this thesis report. This is submitted to James P Grant School of Public Health (BRAC University) as a partial fulfillment of Master of Public Health course.

2.8 Ethical considerations

Rights, anonymity and confidentiality of the respondents were respected in all phases of the study. All the interviews were conducted with a verbal informed consent of the respondents. Written consent was not taken – considering that abortion was a sensitive issue and the respondents were rural women, it was assumed that an effort to take written consent (asking for a signature or thumb print) could deter the respondents from participating. Through verbal consent process, the type and purpose of interview; issues of anonymity and confidentiality; voluntary participation and freedom to discontinue the interview/discussion at any stage; and absence of any known risk or benefit for participating in the study was explained beforehand. (Verbal consent form used for survey respondents has been given with the survey questionnaire in *annex 2*.) However,

as an appreciation for cooperation, all participants of FGDs and in-depth interviews were offered refreshment.

No judgmental statement was made on opinion or experience shared by respondents in any interview or discussion. Photograph was taken in two FGDs with the permission of the respondents. No audio records were made. Due verbal permission was taken from the Medical Superintendent of the hospital to interview clients and the counselor, and to use the relevant hospital records. To preserve anonymity, all findings are presented without ascribing names or identifiable personal description.

The findings from different methods and tools used in the study are presented in an interwoven manner in this section. The findings have been organized in certain themes arising from the qualitative tools. Relevant outcomes from survey and hospital records review have been placed wherever applicable. In this section, the context of safe abortion in Dhading district is initially outlined. It is followed by the description of socio-demographic characteristics of survey respondents. Then socio-cultural context of having an abortion, as perceived by the participant women, is described. It is followed by an elaboration of the women's knowledge related to safe and legal abortion, and their own attitude towards liberalization and abortion rights. At the end of this section, an elaborate account of abortion seeking practices prevalent in the villages from the women's perspectives is presented. Discussion of the findings is then carried out in a separate section.

3.1 Context of safe abortion services in Dhading district

Dhading is a hilly and mountainous district located to the west of Kathmandu. It has 50 Village Development Committees (VDCs), and its district headquarter, Dhadingbesi, is located about 90 km from Kathmandu. A national highway going to Kathmandu passes through some of its southern VDCs. Dhadingbesi is about 20 km to the west from the highway, and linked by a black-topped road. Some VDCs surrounding the headquarter have rough road access, most of them not functional in rainy season. Some VDCs, particularly in the northern side, which do not have road access are more than a day's walk from Dhadingbesi.

There's a district hospital at Dhadingbesi, with only a male doctor at present (total sanctioned post for the hospital is 3). The hospital has safe abortion service provided on a daily basis. The doctor provides the service. This service was started in September 2004. Initially Rs. 1500 (US\$ 21¹⁰) was charged for the service. It was reduced twice bringing it

¹⁰ @ US\$ 1 = Rs. 70. Only approximate figure in US\$ is given.

down to Rs. 900 (US\$ 13) in May 2006. Certain allowance from the service charge collected is given to the staffs involved in providing the service – Rs. 600 (US\$ 9) to the doctor, Rs. 100 (US\$ 1.50) to the nurse, and Rs. 50 (US\$ 0.75) to the cleaner (peon); remaining Rs. 150 (US\$ 2) goes to the District Hospital Development Board¹¹. There is a provision of service fee exemption for poor clients on the recommendation of the doctor. In the fiscal year 2004-05, a total of 344 clients received the service, which increased to 413 in 2005-06 making an average of more than one client in a day.

Until the December 2006, only the district hospital provided safe abortion services in the district. From January 2007, Marie Stopes Clinic (an NGO clinic) is said to be starting the service in Gajuri, a marketplace on the national highway.

3.2 Socio-demographic profile of survey respondents

The survey was carried out with married woman of reproductive age (15 – 49 years). The socio-demographic distribution has been outlined in *table 2* (given on *page 20*). The age of the respondents ranged from 20 to 49 years, with mean age being 30.5 years. Caste wise, more than half of the respondents were Newar (57%), followed by a quarter Brahmin/Chhetri (26%). Almost all of the respondents were Hindu by religion (96%). The caste and religion distribution of the respondents is very dissimilar from the distribution of population in the district, since the selection of study sites was not random.

Less than one third of the respondents had received any form of formal schooling (29%). Around one third had received some kind of informal education (36%) and another one-third did not have any education (35%). Most of the women mentioned that their primary occupation was agriculture (90%). The number of pregnancy the respondents ever had ranged from 0 to 10, with mean number of pregnancy being 3.21.

¹¹ The board is a managing body of the district hospital. It is responsible for allotting service charges in the hospital.

Table 2: Socio-demographic characteristics of survey respondents (n = 72)

Variable	Minimum	Maximum	Mean
Age	20	49	30.49
# of pregnancy	0	10	3.21

Age	Frequency	%	Education	Frequency	%
20-25	24	33.3	None	25	34.7
26-35	31	43.1	Informal	26	36.1
36-49	17	23.6	Primary	11	15.3
			Secondary	9	12.5
			Higher secondary	1	1.4

Caste	Frequency	%	Occupation	Frequency	%
Newar	41	56.9	Agriculture	65	90.3
Brahmin/Chhetri	19	26.4	Teaching	1	1.4
Kami/Damai/Sarki	8	11.1	Business	1	1.4
Gurung	4	5.6	Skilled labor	2	2.8
			Housewife	3	4.2

Religion	Frequency	%
Hindu	69	95.8
Buddhist	3	4.2

3.3 Abortion in socio-cultural context

Nepal is predominantly a Hindu and Buddhist country, and the societies in rural area are relatively conservative. Keeping in mind the fact that abortion, like many other reproductive health issues, is not usually discussed openly, the discussions/ interviews were begun with an attempt to figure out the prevailing socio-cultural views on abortion. Many respondents in FGDs were hesitant to speak in the beginning. It was the encouragement of more open women in the group that made almost all participants actively participate in the discussion and express their thoughts. Also, the questions on societal views gave neutral ground for many such respondents to speak up.

3.3.1 Social stigma

There was a unanimous perception of almost all participants of FGDs and in-depth interviews regarding societal view on abortion, like one FGD participant expressed:

The society (gaau-samaaj) does not consider [abortion] good... people say that abortion should not be done.

– FGD participant, 18 yr, Nearby village

The participants related that there was stigma around abortion. They believed it was so because in the villages abortion was generally taken to be related to unwanted pregnancy resulting from socially unacceptable relations and immoral behaviors. Two remarks reflect it:

[People think that] only women with loose character (baraaliyera hideki aaimaai) have abortion. So, people do not consider it good.

– FGD participant, 30 yr, Nearby village

In our villages, abortion is not considered good... Even if a fetus (pet ko bachcha) is expelled on its own [spontaneous abortion], villagers talk about the woman negatively behind her back. They say that it's the fate of the woman due to her bad deeds. It's more if a woman gets an abortion done. People start saying, "the baby must have been somebody else's [illicit]. So she threw it."

– In-depth interview participant, 28 yr, Nearby village

From the views of society in general, as expressed by the participant women, it was so obvious that socially abortion was not readily acceptable. But many claimed that it was mostly the elderly section of population who held such beliefs. Some of them recounted what the usual reactions of elderly people were on hearing that some woman had had abortion. Of them, two explained:

Elderly (budha-paka) say, "It's the job of women to give birth to children. Why should they say that they don't want the baby?"

– FGD participant, 24 yr, Nearby village

They [elderly women] say that they used to give birth to 7-8 children. They ask why these younger women can not give birth to just 3-4 children.

– In-depth interview participant, 22 yr, Far-off village

This also had a bearing on decision making at household level. Many women mentioned that usually couples tend to keep it with themselves and did not want to bring it up to the elderly at home. In most cases, a woman would fear that the parents-in-law would not accept to have their grand-children aborted, as one respondent said:

In some families, mother-in-laws don't allow their daughter-in-laws to take such decisions. If they know, they persuade to give birth.

– In-depth interview participant, 22 yr, Far-off village

However, some women believed that the attitude of the society in general was more liberal these days, even for abortion. In many cases, the women themselves had liberal views that contradicted with what they said the society held. (This will be described in later *section 3.5 on Women's own attitude to abortion.*) One woman's comment kind of summarizes this liberal notion:

Abortion is not considered very well socially. But with time it is changing. Many elderly still say [that abortion is bad]. But many women like us think that abortion is not that bad.

– In-depth interview participant, 29 yr, Nearby village

The views expressed by women above were mostly in the context of married woman who did not want to continue an unwanted pregnancy. Some clarified that the social views were stricter in case of pregnancy resulting from illicit relation – married or unmarried women. It was considered a breach of moral values, an unsocial act which didn't deserve to be forgiven. A young woman's particularly strict statement highlighted this:

Allowing abortion is okay for married women. But it should not be for unmarried. It'll be bad for whole society. [People say] Such girls should not be kept in the village.

– FGD participant, 22 yr, Nearby village

Abortion is a reproductive behavior, and related to sexual activity. So in the village context it was obvious that abortion entailed shame. This had a considerable implication in decision making as many women would not even want to talk about their intention to terminate a pregnancy with anyone, as was evident in one woman's remark:

Many women hide [that they don't want to have the baby] because they are ashamed even to tell anyone. How would they go for abortion [even if they think of terminating a pregnancy]?

– FGD participant, 40 yr, Far-off village

3.3.2 Religious beliefs

In the FGDs, a number of women thought that the view of society on abortion was an influence of religion. Most Hindu, and all four Buddhist and one Muslim participants stressed that the religion did not allow abortion. Responding to the question on what religious views on abortion were, one participant's response was:

Religion says it's a sin... It's like killing of a baby. So it's a sin.

– FGD participant, 25 yr, Far-off village

However, none of them were able to clearly outline what exactly was the religious dictum on abortion. Some particular beliefs about the women who seek abortion seemed to have influenced the understanding of women about religious point of view, as two women stated:

People say that... prayers offered [by those who have had abortion] are not accepted. They are not blessed by the ancestors (pitree).

– FGD participant, 22 yr, Nearby village

If a woman goes for abortion, she won't see the face of [give birth to] a son in next seven births.

– In-depth interview participant, 45 yr, Far-off village

3.4 Knowledge of abortion issues

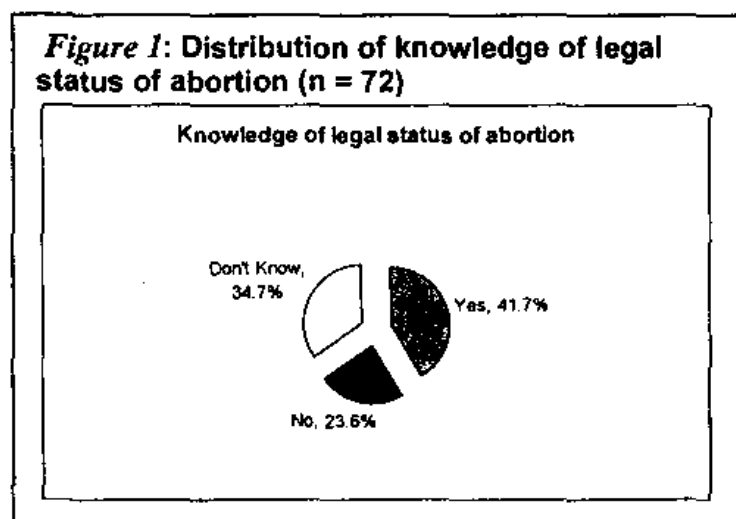
All 41 respondents of FGDs (except two respondents) in general understood the meaning of abortion – spontaneous and induced both – though their definitions varied. Most women considered that the loss of baby from the womb anytime during pregnancy was abortion. Nepali term for abortion, '*garbhapatan*' was understood by all. Locally some other terms – like *adhekro jaanu/ tuhinu*, *ragat-taali maa parnu*, *bachcha fyaaknu/ tuhinu*, *garbha tuhinu/ tuhaaunu* – were used but were not common. Most women also expressed their ignorance regarding the techniques of abortion – traditional as well as modern – except for a few who mentioned about some oral medicines and the word 'curette' used for abortion.

3.4.1 Legal status of abortion

Only about half of the respondents of FGDs knew that abortion was legal in Nepal. But they hardly knew of conditions under which abortion was allowed. The most recurring comment was – "*A woman is allowed if she has too many children*". More interesting were some of the recurring views on conditions that would make an abortion illegal – "*If a married woman is pregnant from another man...; if a woman has not given birth to any children yet...; if it's without husband's consent...*" Only two respondents knew that any woman could avail abortion service up to 12 weeks gestation without restriction. It was remarkable that most women knew about these things from radio. Some of them knew

from peers or female community health volunteers (FCHV). A few also knew from television and newspaper/magazine.

Findings on knowledge of the potential clients on legal abortion and safe services from the cross-sectional survey conducted in the same two VDCs are very much in line with



that of the FGDs. In the survey, only two-fifth of the respondents knew that abortion was legal in Nepal (42%), as shown in *figure 1*. However, there was no significant difference between the respondents of nearby and far-off sites ($\chi^2 = .006$, $p = .937$), rather they were very similar. Out of those who knew abortion was legal in Nepal, about

two-third could say at least one condition for legal abortion (70%) and half could say at least one condition in which abortion was considered illegal (50%). However, no respondent could mention more than one condition each for legal and illegal categories. Also, none were aware that a woman could freely seek abortion for any reason up to 12 weeks.

It can be seen in the *table 3* that one third of the women who knew about the legal status of abortion heard it from radio (33%) and two-fifth from friend or family (40%).

Table 3: Source of knowledge of legal abortion (n = 30)

LEGAL ABORTION	
Learnt from	Percent*
Friend/family	40.0
Radio	33.3
TV	13.3
Health worker	13.3
FCHV/TBA	10.0
Poster/pamphlet	3.3
Newspaper/Magazine	3.3

* Total may add to more than 100% due to multiple responses.

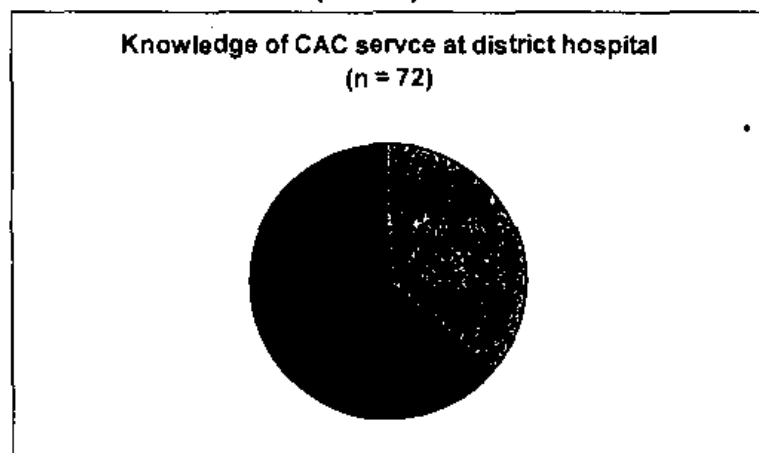
3.4.2 Availability of safe abortion services

Most respondents of FGDs from nearby village knew that safe abortion services were available in the district hospital. Some of them were also aware of the approximate cost

of the services in the hospital. On the other hand, very few respondents from far-off village knew about the service in the hospital.

Poor awareness of availability of safe services in the district was evident in the survey. About half of the respondents said that there was a facility in the district where safe abortion services were available (49%). But only three-fourth of them correctly knew that it was in the district hospital (74%). However, as shown in *figure 2*, of all the

Figure 2: Distribution of knowledge of availability of safe abortion service (n = 72)



respondents, only little more than one third correctly knew that safe abortion services were available in the district hospital (36%). On segregating the responses between two surveyed VDCs, it was found that nearly half from the nearby site correctly knew this (45%), whereas only

a quarter from the far-off site did (25%). But this difference was not found to be statistically significant on cross tabulation and Chi-square test ($\chi^2 = 3.1$, $p = .079$).

3.4.3 Safe and unsafe abortion

In FGDs and in-depth interviews, understandings of safe and unsafe abortions were elicited. Their meanings of safe and unsafe abortions were varying. Two of the respondents actually explained safe abortion as “...[abortion] done in a good way by trained person in a place with good facilities” – words almost qualifying for a book definition! But for most, if there was no complication later on, it was safe.

I think if [abortion is] done in a good way without harming the woman's body, then it is safe
– FGD participant, 25 yr, Far-off village

I think if there is no problem [complication] then it's safe. 'Medical' [village pharmacy/clinic providing abortion] here is safe... I'll go to the 'medical' if I want to have abortion.
– In-depth interview participant, 32 yr, Far-off village

There were few (only from far-off village) who would agree that abortion services in the villages [provided in local pharmacy/clinic by paramedics/nurses] were safe. A number of women from both sites believed that the big hospitals (referring to the district hospital and hospitals in Kathmandu and other cities) would have safe services, and the services in the villages were not safe.

3.5 Women's own attitude to abortion

3.5.1 Liberalization of abortion

As mentioned in an earlier section, socio-cultural beliefs in general on abortion are stigmatizing. However, most of the women participants of FGDs and in-depth interviews seemed to have a view contradicting and challenging these beliefs. Many of them considered the liberalization of abortion as a positive step. The women narrated few old instances of other women, who were in problem due to unwanted pregnancy and often could not get abortion service; or when they got it done clandestinely and had complications, they could not seek formal medical care. So they stressed that women should be able to have abortion done when they had unwanted pregnancy. But some cautioned that this might be harmful. Very few were completely against the idea of liberalization, as one said:

If abortion is allowed, there will be social problem (samajik bikriti).

– FGD participant, 40yr, Far-off village

3.5.2 Abortion Rights

A majority of the women approved of a married woman's right to abortion. They felt that a woman should be able to have abortion if she had many children and did not want more. But fewer women approved that an unmarried girl should have the right to abortion. One young participant said:

Even unmarried woman should be allowed, though it might increase wrong behaviors among unmarried girls. Otherwise they get into great difficulty in society... It's better for unmarried to avoid getting involved [being pregnant]. But some girls do get into it. And sometimes girls are forced and they become pregnant. If they are not allowed to have abortion, they will have very difficult life in society. They might even commit suicide.

– In-depth interview participant, 22 yr, Far-off village

However, many of these respondents mentioned that only under difficult conditions should unmarried be allowed to have abortion. Few strictly opposed allowing abortion to unmarried girls saying that it would increase immoral behaviors amongst girls and bring social problem (*samajik bikriti*).

The findings from the survey also suggest that majority of women supported abortion rights of women. As shown in *table 4*, two third of the respondents approved that a married woman should have the

right to abortion (67%) and little less than that approved that an unmarried girl should have the right to abortion (63%). Rest either disapproved or were not sure, although the proportion of those who disapproved explicitly was more for unmarried girls (33%) than for married women (25%). As shown in *table 5*, Cross-tabulation and Chi-square test of knowledge of legal status and

Table 4: Approval to woman's right to abortion (n=72)

Response	For married Woman	For unmarried Girl
Yes	66.7%	62.5%
No	25.0%	33.3%
Don't know	8.3%	4.2%

Table 5: Chi-square test of knowledge of legal status of abortion with attitude variables

Variables	χ^2	P value
Approve married woman's right to abortion	1.6	0.205
Approve unmarried girl's right to abortion	5.4	0.020

* p value < .05 is significant.

attitude towards abortion rights of unmarried females showed significant difference in the attitude between those who knew that abortion was legal and those who didn't ($\chi^2 = 5.4$, $p = .02$). However this difference was not significant as regards to the abortion rights of married women ($\chi^2 = 1.6$, $p = .20$).

3.6 Perception of women on abortion practices in the villages

In FGDs and in-depth interviews, an effort was made to find out if any of the respondents had the experience of abortion, in order to elaborate the lived experience. None of the respondents admitted ever having an abortion done, though few shared the stories of spontaneous abortion they had experienced. However, most of the participants said they knew that women in the villages did access abortions. Many thought that it was not very common, but existed. It might be due to social stigma, participants did not want to share that women of their locality go for abortion. Most tend to say that they had heard only of women from other locality (ward or village) going for abortion. There seemed to be a component of social desirability in women's responses. Since it is a sensitive issue, no effort was made to probe further into the experiences of the participants' own locality. The women gave their responses based more or less on what they heard from others in their communities.

Table 6: Reasons given by survey respondents for seeking or not seeking abortion

In the survey, there were 5 respondents who said they had an abortion before. Of them, two had it done in the district hospital and 1 in a private clinic. Other two did not mention where. Similarly, there were 6 respondents who said that they wanted to have an abortion, but did not have. The reasons mentioned by these two

Reasons for having the abortion	# of respondent
Pregnancy endangered my health	2
The child was conceived by mistake	1
It was a girl child	1
Don't know	1
Reasons for not having the abortion	# of respondent
It was too costly	1
I was afraid of family or society	1
I consider abortion as a sin	2
I was refused by a health-worker	2

groups of respondents are given in *table 6*. Since the number of such respondents was very small, it could not be compared across other variables.

3.6.1 Socio-demographic differences

In the FGD and in-depth interviews, many respondents thought that all types of women sought abortion. They remarked that anyone could have unwanted pregnancy. There was no difference amongst rich and poor; educated and illiterate; or high or low caste. But a

few had the opinion that it was different in rich and poor. Like a woman in FGD, few thought seeking abortion by poor women was more common than the rich:

Many women do go for abortion in village. Mainly poor [women] go. They usually do not get the 'operation' [permanent sterilization] done. They think it will make them weak. They keep becoming pregnant... and when they have to have abortion, they even sell their crops...

– FGD participant, 36 yr, Far-off village

Few others had opposing view. They felt that rich people had more money; they were educated; they had the access; so abortion seeking was more common among them.

Some of the findings, that abortion seeking is not much related to caste or literacy, are also reflected in the findings from the hospital records.

The socio-demographic characteristics of clients who sought abortion (CAC service) in district hospital over the period of seven months (mid-April to mid-November 2006) are outlined in *table 7*. The age of clients ranged from 16 to 45 years, with mean age being 28.9 years. About a quarter of the clients were 24 years or under (24%) and majority was in the age range of 25 to 35 years (60%). The caste distribution is given in *figure 3* (given on page 30). The caste distribution is somewhat proportional to the distribution of population in the

Table 7: Distribution of CAC clients in hospital

Variable	Minimum	Maximum	Mean
Age	16	45	28.9
No. of pregnancy	1	10	4.1
No. of children	0	9	2.9

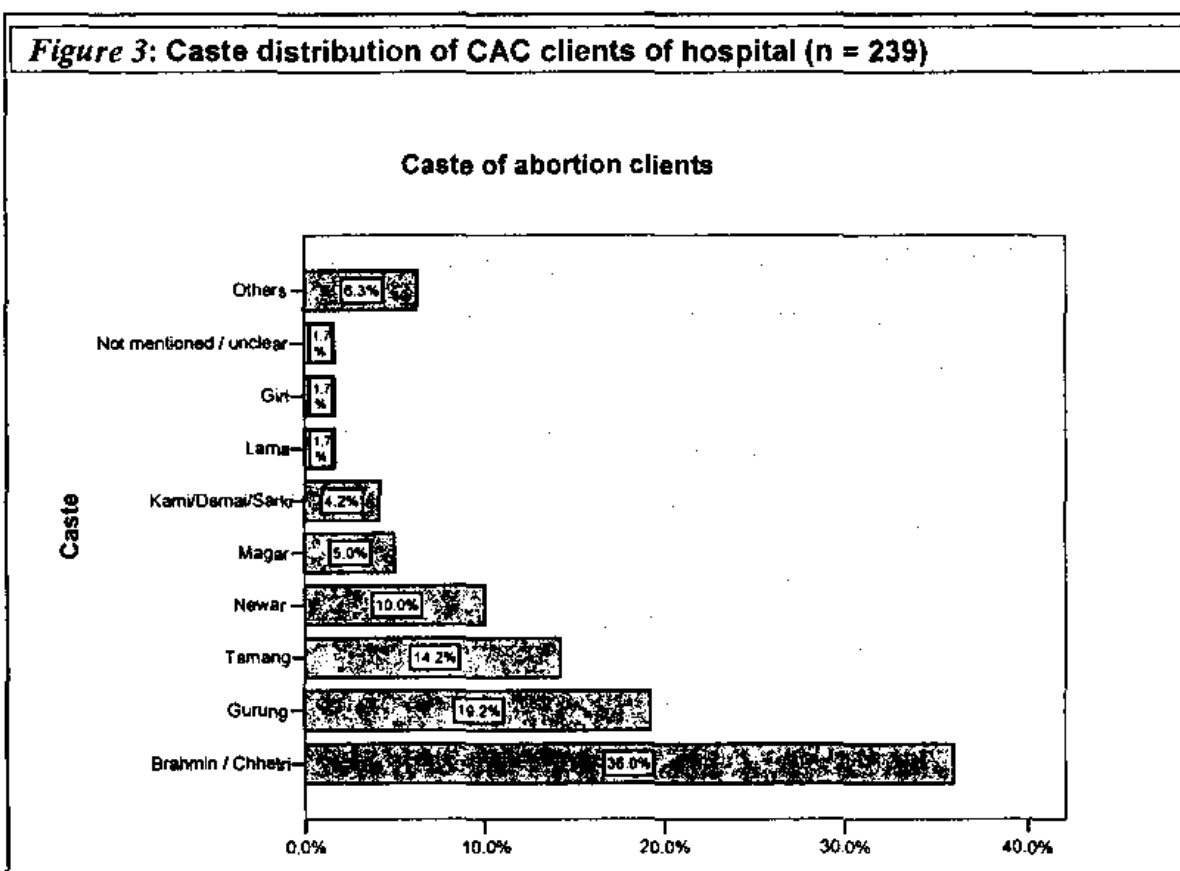
Age	Frequency	Percent
16-24	58	24.3
25-35	142	59.4
36-45	39	16.3

Education	Frequency	Percent
None	89	37.2
Informal	62	25.9
Primary	25	10.5
Secondary	43	18
Higher secondary	3	1.3
Not mentioned	17	7.1

# of pregnancy	Frequency	Percent
1	13	5.4
2	24	10.0
3	66	27.6
4	46	19.2
5 or more	90	37.8

# of children	Frequency	Percent
0	13	5.4
1	26	10.9
2	73	30.5
3	46	19.2
4 or more	81	34.0

district – the *Janajati*¹² (Tamang, Magar, Gurung) being the highest, Brahmin/Chhetri¹³ and Newar being next. However the proportion of *Dalit*¹⁴ (Kami, Damai, Sarki) is smaller than that of the district (11%) [CBS Census 2001]. Less than one third of the clients had received any form of formal schooling (30%). Around a quarter had received some kind of informal education (26%) and more than one-third did not have any education (37%). This seems to be near representative of district population, the female literacy rate of the district being 34% [CBS Census 2001]. The occupation of most of the clients was recorded as housewife (95%). The number of pregnancy the clients ever had (gravida) ranged from 1 to 10, with a mean being 4.1. Likewise, the number of living children the clients had (mentioned as parity) ranged from 1 to 9, with a mean being 2.9. Four out of 239 clients were recorded as unmarried. But as per the CAC counselor, there are more than that – in her calculation it was about 2-3 percent of all clients.



¹² *Janajati* are the ethnic groups.

¹³ Brahmin/Chhetri are the high caste Hindu groups.

¹⁴ *Dalit* are the low caste Hindu groups.

3.6.2 Reasons for seeking abortion

A number of participants of the FGDs thought that most commonly women who already had desired number of children (*santaan ko rahar pugisakeko haru*) sought for abortion. Apart from completed family, other reasons mentioned for seeking abortion in the villages were – having a small baby and not ready for another pregnancy; pregnancy resulting from illicit relationship; pregnancy in unmarried girls; and contraceptive failure. Few respondents came up with the issue of sex-selective abortion, but thought that it was very rare in their villages. However, career or study was not mentioned in any discussions as a reason for seeking abortion.

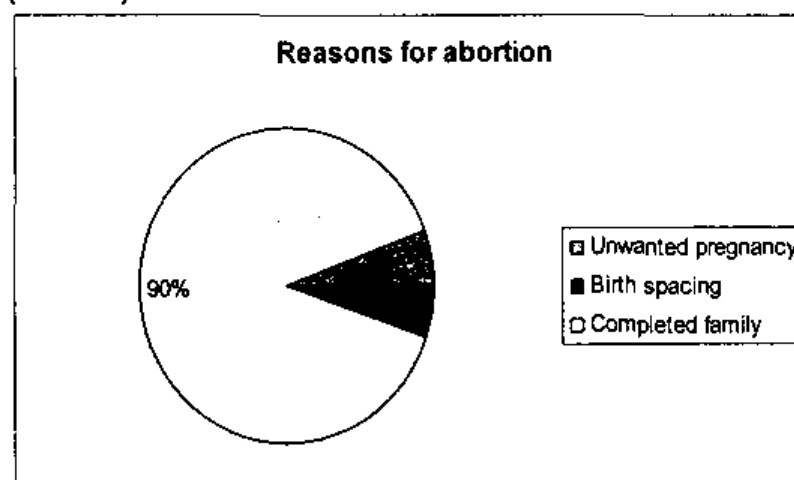
In line with what women in FGDs said, the hospital records also showed that amongst the clients ‘completed family’ was the most common reason for seeking abortion (89%). As shown in *figure 4*, other reasons were unwanted pregnancy and birth-spacing (5% each).

There were some cases of contraceptive failure but were not mentioned as such, as per the counselor. Such cases were placed under complete family category.

3.6.3 Decision-making to terminate a pregnancy

The women in FGD and in-depth interview mentioned that, in the villages, the decision making for abortion is usually limited to the couple. Many thought that women did not usually inform parents-in-law for fear of refusal. But a few mentioned some cases where mother-in-law had supported woman’s decision to go for abortion. It emerged that in some cases mothers, sisters and peers were also consulted by women for making decision. Most felt that in case of unmarried girls, they talked to their peers or mothers

Figure 4: Reasons for abortion of CAC clients of hospital (n = 239)



for deciding. To a query whether a woman would decide alone on their own, most women responded that it was not at all possible in their context. One of them explained:

If a woman has more children that necessary, it is very difficult for her. It can be a big burden... Husbands usually don't feel the problem. But a woman must always decide [for abortion] after consulting with husband. Other family members may or may not know. It's not a big issue. But a woman should always talk to her husband. Otherwise the woman will be in big problem... I think woman has the right over the decision on abortion, but how can she go if her husband doesn't agree?

– In-depth interview participant, 28 yr, Nearby village

3.6.4 Channels to seek provider

The participants in the FGDs said that, once women thought or decided to have an abortion, they usually contacted ‘medical’ (local pharmacy/ clinic) in the village or their peers for advice as to where to go. Some women spoke to other women who had abortion earlier, or they went to the FCHVs. Very few thought that women contacted health worker at the health posts in the villages to get advice for abortion.

If a woman visited a pharmacy or clinic in villages, she was either referred to a listed or unlisted facility, or was provided abortion service in the pharmacy itself. The informal interviews with two pharmacy owners threw more light on this. Relevant excerpts of those interviews are given in *box 1* (on page 33) and *box 2* (on page 35).

3.6.5 Commonly preferred service provider

A clear difference emerged in the FGDs, between perceptions of women of the nearby and the far-off villages, on the place women of their village would generally go for abortion services. It was evident that women of nearby village mostly would go to the district hospital and Kathmandu for abortion service. The women of nearby village mentioned that there was no local provider in their village. In contrast to that, women from far-off village would mostly visit local providers in their own village or surrounding ones.

Women usually have abortion in village itself. They don't go to district hospital. It is far. They have small children. They also have a lot of work at home. So they don't want to travel long for abortion.

– FGD participant, 25 yr, Far-off village

They recounted some pharmacies in the villages provided the service. They also pointed out that some nursing staff and paramedics working in government health facilities provided services in personal clinics/ pharmacy. None of them were aware of any traditional provider in the villages. Women from far-off village mentioned that those who could afford money and have time go to Kathmandu for service. Very few knew about cases from that village going to district hospital for abortion services. According to them, women usually didn't go to [district] hospital as they were not certain about the service availability.

Box 1: Excerpts from informal interview with pharmacy owner 1 (Village X)

Abortion services are available in the hospital. So we send cases to the hospital. Earlier few pharmacies [around this area] had clandestine abortion clinics. But now not many have that service. Most refer clients to the hospital. People [in this area] are being more and more aware of the services in the hospital...

Still some pharmacies [in many areas] sell drugs for abortion. Many have abortion clinics [run by different cadre of health professionals]... Most use oral drugs like 'KLOT', 'pills'...

If it is more than 12 weeks [period of gestation], district hospital does not provide service. If someone comes to me I send such clients to [a particular doctor in] Kathmandu. They get the service there in the doctor's private clinic. They usually charge around Rs 10,000 (US\$ 143). We get up to 30-40% in commission for referring such clients... If they allow CAC [safe abortion services] in private clinic in our district, one can make a lot of money...

It is notable that the findings from the survey reiterate the difference between the two sites on where would a woman generally go for abortion service. Of the valid responses, more than two third of nearby village respondents mentioned district hospital (71%), whereas less than a third of far-off village said so (29%). The cross-tabulation (shown in table 8) and Chi-square test showed that the difference is highly significant ($\chi^2 = 9.3$, $p = .002$).

Table 8: Cross tabulation of preferred abortion service provider with village location (n = 52)

		Commonly visited abortion service provider	
		District Hospital	Others
Village	Nearby	17 (70.8%)	7 (29.2%)
	Far-off	8 (28.6%)	20 (71.4%)

$\chi^2 = 9.3$, p value = .002 (p value < .05 is significant.)

This strongly corroborates with the findings of hospital record. The analysis of the address of the clients showed that majority came from VDCs nearer to the district headquarters. As outlined on *table 9*, two-third of the clients were from the district headquarter and surrounding 15 VDCs. The remaining one-third of them were from other 22 VDCs and few from outside the district. As noted earlier, the district has total of 50 VDC.

Table 9: Proportion of CAC clients coming from areas nearby hospital (n = 239)

Area	Names of the VDC	Percent
Dhadingbesi and 5 bordering (nearest) VDC	Nilkantha (Dhadingbesi), Duwakot, Khalte, Muralibhanjyang, Sankosh and Sunaulabajar	35.6
Dhadingbesi and 11 surrounding VDC	Above six VDC + Chainpur, Dhola, Jyamruk, Kalleri, Katunje and Nalang	53.6
Dhadingbesi and 15 surrounding VDC	Above 12 VDC + Khari, Maidi, Semjung and Salang	66.5

3.6.6 Cost of abortion

In the FGDs, it was seen that even though more women from nearby village were aware of the availability of abortion services in the district hospital, very few knew about the approximate cost of the services there. Almost none of the women from the far-off village had any idea about that cost. But most thought that abortion in general was costly and the cost ran in thousands. They had stories of women paying thousands of rupees for abortion. The abortions provided in the village pharmacies were also costly, as one woman puts it:

I have heard that in the 'medical' [pharmacy in the village], they charge very high. They take money according to the duration of pregnancy – Rs. 2000 (US\$ 29) for 2 months and up to Rs 5000 (US\$ 72) for 4 months.

– FGD participant, 36 yr, Far-off village

The pharmacy owner, who also provides abortion services, confirmed that the rates in the villages were similar to that mentioned by the woman above. (See *box 2* on *page 35*.)

Box 2: Excerpts from informal interview with pharmacy owner 2 (Village Y)

We do abortion is our 'medical'. [Two provide the service together. Further attributes are not mentioned to maintain anonymity.]... About 1 or 2 clients come per month. Sometimes there are more. We take Rs 2000 (US\$ 29) and more depending up on the client and the gestation. We take up to 4-5 thousand (US\$ 57 to 72). We do up to 3 months. We don't do beyond that as it can be dangerous... So far there have not been any complications...

We have our own D&C [dilatation and curettage] sets. We boil the equipment well before using. We give 'Synto' injection [Oxytocin] to all clients after D&C. Sometimes there's little bleeding. We give IV fluids. There has not been big problem as yet.*

People don't want to share but abortion is quite common. They go to different places to get it done secretly. Mostly people from surrounding VDCs come here. Few from this village too come. But they try to go to A and B [2 nearby] VDCs to avoid being seen. Those who can afford to travel and want absolute secrecy, they go to Kathmandu. I don't think many women from this area go to district hospital...

I know abortion is legal and it should be done in hospitals... I don't know the conditions for legal abortions. I don't advertise. But people trust us and come to our clinic...

We have to do D&C. Otherwise it's very difficult to survive on the income of the pharmacy alone. I've been able to make some money due to abortion services. I know there can be complications and problems may arise if a case goes wrong. But we have done so many cases successfully; we can do it well and without complications.

*[*Oxytocin is a hormonal preparation, which causes uterine contraction. It is given after abortion to prevent uterine bleeding.]*

On the issue of cost affecting the service seeking, many believed that women were usually ready to pay if they want to have abortion.

If a woman needs to go for abortion, money is not a big issue.

– FGD participant, 23 yr, Far-off village

But some strongly put their view that poorer section of women can not have abortion service if they have to pay in thousands. A case shared by a respondent sheds light on how costs deter many poor women from having abortion even when they have too many children:

I have heard of a case of a woman pregnant for 3-4 months. It was around one,one and half years ago. She had 4 children and did not want that child. She went to village 'medical' for abortion. The person in 'medical' asked for a huge amount. I think more than Rs 8 to 10 thousands (US\$ 114 to 143) . She then went to Dhading hospital. She was returned from there without service. I don't know why. Later she decided to give birth to the baby. [As heard] She used to joke that it was less costly to give birth than to abort.

– In-depth interview participant, 32 yr, Far-off village

The approximate cost of Rs 1300 (US\$ 19), including service fee and medicines, for abortion services in district hospital was shared with the participants to elicit their view on that cost. Most women labeled that as a reasonable amount. But few still argued that it was not possible for poorer women to go for the service.

Rs. 1000 – 1500 (US\$ 15 – 22) is reasonable (thikai ho). It must be difficult [the procedure of abortion]. We also have to look at the problem it avoids. Even if it's little more, women who want to go for abortion will manage it... Some even sell their jewelry to pay for an abortion. Women pay any price to have abortion when they don't want to keep the baby. I think only very poor women will have difficulty.

– In-depth interview participant, 45 yr, Far-off village

These discussions were focused on the direct cost (service fee and medicines) for seeking an abortion. As mentioned in one quote in *section 3.6.5 on commonly preferred service provider* above, opportunity cost (of losing work) and familial cost (of having to leave small children and household chores) was an important consideration, mainly amongst poor women, while deciding to go for an abortion.

3.6.7 Common complications of abortion

Most of the women in FGDs and in-depth interviews were aware that bleeding is a complication of abortion. Some of them recounted the cases they had heard of other women having bleeding after having abortion with local unauthorized providers.

I heard that in some cases women bleed a lot after abortion. About 3-4 years ago, one woman from our village had abortion in a 'medical' in Dhadingbesi. She had bleeding problem from then. She went again for check up. She was given some medicines. But the bleeding continued up to 6 months. After 6 months she expelled some fleshy mass (maasu ko dallo jasto) and the bleeding stopped. Some said that baby was still there. It was expelled after 6 months of bleeding. I don't know the woman personally. But I heard she's good now. I don't know of any such case nowadays.

– In-depth interview participant, 29 yr, Nearby village

Except for one case explained in a FGD at nearby village, none of them had heard of any death due to complications of abortion in last five years.

I don't know about safe or unsafe abortions. If there is a lot of bleeding then it must be unsafe I think... I have heard of one woman [from another village] who died due to abortion. She lost her life for nothing. I think it was 2-3 years ago. She went to Kathmandu for abortion when she was 7-8 months pregnant. I don't know where that place was. She had some problems later on due to abortion. I don't know whether it was bleeding or some other problem. She was then taken to 'Thapathali' [Central Maternity Hospital in Kathmandu]. [Her family] spent a lot of money but she died there. I heard they spent about Rs 5000-6000 (US\$ 72 to 86) for abortion alone. So I don't like abortion.

– In-depth interview participant, 17 yr, Nearby village

3.6.8 Perception about different providers

In the FGDs, some women from nearby village had the perception that the abortion services in the [district] hospital were good. They had not heard anything negative about the services of the hospital. They thought that the services were safe there. In contrast, women from far-off village expressed their ignorance about availability of the service in the district hospital, let alone the quality of service. On the local providers, the opinion was divided. All women from nearby site and some women thought that it was not good [safe] in the village. But few from the far-off site opined that the service in the village was good and safe, as they hadn't known of any serious problem [complication] in the village clinic. One respondent clearly shared her views:

I have not heard of any unsuccessful case of abortion in the [village] 'medical'... They earn a lot of money by doing abortion. People prefer them. They think the service is good. So women from other villages too come here... I don't know whether the service they are giving is legal or not... I don't know about the [district] hospital... the service in the 'medical' is safe.

– In-depth interview participant, 32 yr, Far-off village

Most participants in the FGDs assumed that services in 'big' hospitals in Kathmandu and other nearby cities (Pokhara and Narayanghat) would be safe. But they believed that only a few people from villages could go there to seek service because of the distance and costs.

3.6.9 Expectations for better abortion service

It was not possible to understand the exact difficulties faced by a woman while seeking abortion service as none of the respondents divulged having such an experience. Nonetheless, the respondents were asked during FGDs what they would expect in a service providing site or from a service provider if they had to go for abortion. Most

women shared a common concern that female should provide the service. They clarified that women felt more comfortable with women to have such procedure. In many cases, they mentioned nurses. In Nepal's context most of the nurses are female. Many of these women thought that service provision by nurses would address their concern of having female provider. Only few mentioned female doctors. One woman, who was informally interviewed, when she was waiting for abortion service at hospital, also had the concern to have service from a female provider. Excerpts from her short interview are given in *box 3 on page 39*) Most of the women from far-off village expressed that the service should be available in the village, or at least in adjacent village – as it would be difficult for many women to go to district headquarter or other cities. Not actually related to abortion, but one case example of a complicated labor shared in one FGD throws some light on the difficulty caused by distance. It was the story of a FGD participant and was narrated by another:

It was just last year. She [pointing to another participant in the FGD] was in labor. It was rainy then. She did not deliver even after a day of labor pain (byetha lageko). Hand [of baby] had come out [hand prolapse]. She had started bleeding. Other woman would have died. Her father is a wise and active man (baatho maanchhey). He arranged for people to carry her to Dhading hospital. It took 14 hours. Bus service [in the nearest road-head] had stopped due to rain. Her luck was strong that she survived.

– FGD participant, 45 yr, Far-off village

Some participants in the FGDs again reiterated their concern to have the services less costly. Few said that those who can not pay should be offered free service. Here it is important to note that only 4 out of 239 clients over the period of 7 months were fully exempted from the service fees for abortion and another 4 were given some subsidy (not more than Rs. 200 i.e. US\$ 3), as mentioned in the hospital register. The cost of the subsidy is borne by the hospital itself, as there are no separate funds from government for such subsidies. In the FGD, there were also concerns about regular availability of service. A respondent from nearby village quoted an experience of a FCHV who takes women from her village to hospital for abortion:

One woman she [FCHV] took to the hospital [for abortion] was asked to come next day. Hospital's 'didi' [nurse] told them that doctor was very busy that day. Next day she went again and got the service. There is only one doctor who gives the service. Other doctors should also do it.

– In-depth interview participant, 29 yr, Nearby village

Many in the FGD felt that women should not be returned like that; the service should be available everyday. The FCHV, who used to take clients to the hospital, also stressed that. According to her, many of these women go without telling the in-laws, and they find it problematic going repeatedly to the hospital. Excerpts from her interview are given in box 4 below. Though some of the women mentioned that the service should be good and without problem [complication], none of them mentioned issues of privacy and behavior of the providers – probably because they could not exactly imagine themselves in that context.

Box 3: Excerpts from informal interview with a client waiting for abortion service at the hospital

I knew [about this service in the hospital] from radio. A friend also had told me... I have 2 children – 1 son and 1 daughter. My younger child is 2 years. I don't want any more babies. I was not using anything. I conceived unintentionally this time. So I've come to abort... I have brought my mother... People go for abortion secretly... But I don't think that's right. I've come openly. I think all women should come for abortion openly...

It's good that abortion is allowed... But I think it's not good to allow unmarried girls for abortion.... I know a doctor [male] will do it. If it could happen as I wished, I would have got from a nurse [female]... The cost is very reasonable. Thankfully, it's available here... otherwise I had to go to Kathmandu for this. It would be very difficult...

Note: Excerpts from the informal interview with the CAC counselor of the hospital, which was helpful in triangulating many of the findings, are given in box 5 on page 40.

Box 4: Excerpts from informal interview with a FCHV of nearby village

I distribute family planning devices – condoms and pills... I also tell women about abortion in [mothers' group and other] meetings... I received training on abortion [by a local NGO]... After that I have taken some women to district hospital for abortion. I accompany them if they come to me and ask for advice and help... Usually husband and wife ask me... Most of them want to hide from parents [in-laws] and neighbors...

The (CAC) service in district hospital is good as far as I know... So far, only once a client taken by me was called for next day as doctor was busy with other work. Otherwise, all other clients were given CAC service on the same day... There should be at least one more [provider] so that women don't have to return if the doctor is out or is busy in some other work... It would be better if nurse provided the service in district hospital – it would be easier for women and nurses are always available...

Box 5: Excerpts from informal interview with the CAC counselor of hospital

CAC service is available daily. The fee is Rs 900... Client has to buy medicines herself. The average cost of medicines is around Rs 400...

Most come at 6-8 weeks [of pregnancy]... Some cases of more than 12 weeks come. They are returned without service but they are counseled before sending... I think about 5% are such cases... I have seen clients up to 18 week gestation come for abortion. Most of these clients persist and request for abortion even when they are explained. One woman with 18 weeks gestation came 4 times requesting for the service... I have asked [some of them]. Many first try to get abortion in villages from health worker there. They are usually given some oral medicines. If nothing happens, they then send to district hospital. Due to this [delay] many cross 12 weeks and they don't get service here... Some cases have even come with complications...

We also send some 'primi' [women with first pregnancy, if they agree to give birth to the baby.... Many of them agree after we tell possible complications [including infertility]. Some unmarried also have come. Many of them lie and present as married. So the record shows very few unmarried, but there are more than that. Usually they also lie about their village. But I guess on an average about 2 to 3 client for every 100 clients are unmarried. Most [clients] are from the VDCs around the district headquarter. Very few come from faraway villages like Ree and Tipling. Clients from electoral constituency no. 3 [VDCs near the national highway] go to Kathmandu or Chitwan...

Clients from remote VDCs are not coming here much... It's not usually due to money. Most people there are illiterate. They give birth to 6-7 children on average. They don't have information on abortion services... Many don't understand Nepali [their mother tongue is different]... It's a long distance for them. They have to walk a lot.... Many women who come for CAC do not inform others in village about the service. They try to keep it secret. [In such circumstances] how will others know easily?

Few women have come for repeat abortion. They don't use family planning methods, become pregnant again and come to abort... We counsel every case after procedure and give them contraceptive... But some do not want to use... Some say their husbands are out...

We tell every client about possible complications before hand... About 2 to 3 % have come with bleeding later on... Mostly cases with near 12 weeks have such complication. So far I am not aware of any case coming with infection... But such follow up cases are not recorded in CAC register. If a woman comes for follow up or a repeat abortion, she's again recorded as new case...

Few clients come with referral referred by health posts [peripheral health facilities]... The referred cases are not recorded as referred in any register. So, it can not be found from the records...

So far, I don't of any case of rape or incest coming after 12 weeks... But if such case comes, she has to be referred to Prasuti Griha [Central maternity hospital in Kathmandu].

3.6.10 Issues of changing fertility and family planning

In the FGDs and in-depth interview, the issue of changing trend of family size and family planning were also touched upon as they have implications for abortion too. Most women in the FGD were aware of family planning; many had used some form of contraception sometimes in their life. The survey also showed that majority had heard of family planning (96%) and two-fifth of the respondents had used at least one contraceptive method in their life (39%). The FGD respondents said that contraceptives were easily available (referring mainly to condom, oral contraceptive pills, injectable hormonal contraceptive) in the villages. Some talked about the trend of changing family size. They felt that small family had become a norm. Few even mentioned that the changing fertility trend was due to increased use of family planning methods,

Earlier women used to give birth to 7-8 babies. Now many use temporary contraceptive (asthaai saadhan). Most have only 2-3 babies

– FGD participant, 28 yr, Far-off village

However, some felt that many needy women did not use them and landed up with unwanted pregnancies. They also showed their concern on contraceptive failure citing few instances. All the women strongly felt that abortion should not be taken as a substitute – a reason for not using contraceptives.

After the abortion services in the hospital, the clients are counseled and are offered an informed choice of contraceptive. As shown in *table 10*, more than four fifth of the clients of the district hospital were provided with some kind of family planning method (83%) following abortion service, half

Table 10: Contraceptive given post-procedure to CAC clients in hospital (n = 239)

Contraceptive provided	Frequency	Percent
None	41	17.2
Condom	12	5
OCP	8	3.3
Depo injection	114	47.7
Norplant	10	4.2
IUD	35	14.6
Sterilization	19	7.9

of those had received *Depo injection* (injectable hormonal contraceptive). However, 17% did not receive any contraceptive. Probably they refused. On the register, it was recorded as 'no', 'no need', or 'husband outside' or the cell was blank.

Safe and legal abortion services are relatively new in the context of Nepal. The services are not yet widely available. However, the number of institution providing such services is gradually on the rise. At such a time, this study was an endeavor made to explore women's understanding of abortion in their social context; recognize the aspects of decision-making to terminate an unwanted pregnancy; and to note actual trend of service seeking by women in remote hilly villages. The main objective of the study was to understand the barriers that could prevent a woman from being able to terminate an unwanted pregnancy in a safe way. Women of reproductive age group who are the potential clients of such services were taken in this study and their perspectives were gathered using different tools. It should be noted that no actual case with a history of induced abortion was found in FGDs or in-depth interviews. So the results are based on the perspectives of women on abortion practices in the villages, and not on accounts of lived experience. However, analyzing the information that came out in the study, factors that directly or indirectly could influence the access of a woman in a hilly village to safe abortion services have been sketched out in this discussion. Initially in this discussion, the proportion of needy women in the district who are not able to access (or have not accessed) the abortion services in the district hospital has been estimated. It is followed by discussion of the barriers to access safe abortion services. At the end of discussion, some recommendations have also been made.

4.1 Barriers to access safe abortion services in the district

Statistics on the actual number of induced abortion that takes place in the district are not possible to obtain at present. But based on the regional statistics, a crude assumption can be made – at least around 1100¹⁵ unsafe abortions take place every year in Dhading. As estimated from the hospital records, currently hospital serves about 410 clients per year. These figures, however simplified they might be, does point that majority of women

¹⁵ Calculated using following estimated rate and population size: Unsafe abortion rate for Asia is 13 per 1,000 women aged 15-44 years [WHO 2004]. Estimated population of women aged 15-44 years is 82,939 [DHO Dhading 2006]. It is an estimate of unsafe abortions only. The estimate for all induced abortions would be higher.

terminating their pregnancy do not seek abortion services in the hospital. Given the geographical situation of Dhading, which is hilly and mountainous, and safe services availability limited to one hospital in the district, most of these can be assumed to be receiving service from local unqualified providers.

From the findings of this study, it is evident that socially seeking abortion is not an easily acceptable behavior. Mostly the elderly section of the society, which has lot of influence in the community and household preferences, carries greater weight of such belief. They do not seem to accept the trend of having small families; rather consider that a woman's role is to bear as many children as possible. Parents-in-law take pride in having more grand-children. With that attitude, a pregnancy can not be unwanted, unless it results from immoral relations – any relation outside the wedlock is illicit in the society. It is further intensified by religious consideration that abortion is like taking a life, a sin with repercussions across woman's several lives.

It's encouraging that most women participating in this study had positive attitude towards abortion and abortion as woman's right, including unmarried ones'. However, in the prevailing socio-cultural context where abortion is stigmatized, a young woman may not be able to decide to seek abortion, fearing rebuke from elderly in the family or community. There is also an element of shame associated with abortion, it being a reproductive behavior, which can keep a woman from sharing with anyone her intention to terminate a pregnancy. At household level too, a woman usually does not prefer confiding with mother-in-law, lest she would be coerced to carry on the pregnancy. In most case, husband is the only person a woman would discuss with. But in some instances, husbands also try to keep it from family members or others due to stigma. At times it could be due to husbands' concern that the issue of infidelity might arise [CREHPA 2005]; or due to husbands' own disapproval as fewer men than women approve of abortion rights of women [CREHPA 2006]. In such circumstances, a woman is highly likely to be deprived of any right information, advice or support to make appropriate decision regarding an unwanted pregnancy, or to seek service at an appropriate place. Even when a woman does seek service, she is more likely to do it

clandestinely and, more often than not, landing up with an unqualified provider. The dynamics are even harsher for a woman conceiving outside wedlock, mainly unmarried ones.

The level of awareness, amongst the respondent women of this study, regarding safe and legal abortion services reflect that majority still does not have right information to make decisions, and to take appropriate steps, to seek termination of pregnancy timely and at right place. As mentioned in a review article, “legal awareness in India is as low now as it was when abortion was legalized three decades ago, ...and this prompts large number of women to clandestine and expensive provider” [Ganatra B and Johnston H 2002]. Levels of unsafe abortions are still very high in India [Johnston H 2002]. This has an important implication for Nepal to emphasize on raising awareness, as it is in its initial stage of implementation of legal abortion services. The survey has showed that only two-fifth of these women is aware that abortion is legal in Nepal. This is a better proportion compared to what was found earlier in a study in 2005, where only a fifth of rural women were aware of this [CREHPA/PPFA 2005]. Though two study sites may not be compared on the same scale, but it does point towards a rising awareness level. However, at the same time it is disappointing that only a very few in FGDs, and none of the respondents in survey, were aware of the safe gestational limit of 12 weeks permitted by law for any woman. This awareness is way too low compared to that of general urban population (42%) shown by a recent survey [CREHPA 2006]. This is very important to note because many women who manage to overcome many barriers to seek abortion from safe providers are turned down due to this gestational limit. Many of them end up carrying the pregnancy further, some being guided into having an abortion from a provider at government unapproved site, which can be aptly labeled illegal.

The knowledge about availability of safe abortion services in the district (hospital) is found to be low at 36%. Though not significantly different, the finding of comparison between far-off and near sites suggests that women in distant village are less likely to be aware of this than those near the district headquarter. It also throws light on what women rightly expressed in FGDs – that women from far-off village go less to district hospital

for service because they are not aware of it. In the same line, it is remarkable that significantly fewer women from far-off village (as compared to those of nearby village) in the survey mentioned that women from their village generally went to district hospital for abortion. Review of hospital records also support this – two third of women seeking service in the hospital are from the less than a third of all VDCs of the district; these VDCs are closer to district headquarter compared to remaining two third. From all these, the ones from far-off villages can be safely assumed to be mostly resorting to unqualified providers in the villages.

It's evident from several findings of this study that distance plays a crucial role in deciding to have an abortion and seeking the service. This corroborates with the findings of a review on barriers to health services (in general) based on several studies that “distance to facilities impose a considerable cost on individuals and... [is] often seen to negatively impact service utilization” [Ensor T and Cooper S 2004]. Though the direct cost of abortion in safe facility is less than local unqualified providers in many instances, for the women of remote villages the distance to the hospital entails different additional costs – indirect costs like travel and stay; opportunity costs like loss of work during harvesting season; and familial costs like leaving small children at home without anyone to take care of. It is more pronounced in hilly rural areas, like most parts of Dhading district, where the facility of transportation is limited and women have to walk long distances to avail a service. In such circumstances, decision to travel a distance might be bigger for a woman of remote village than the decision to seek abortion itself. Moreover, the availability of alternatives, albeit unsafe, in the villages gives an easy and apparently cheaper option.

‘Medicals’ or local pharmacies/ clinics in the villages have a substantial role in the dynamics of abortion care seeking. They are usually point of first contact from many village women seeking abortion service – they are the source of information, advice, and referral; and, at some places, the service provider as well. This compares well with rural medical practitioners in a part of India who are “[unqualified] providers of abortion services as well as agents for [qualified or unqualified] service providers; and were found

to have a negative impact on women's health, and gain financially [from them]" [Barnes L 2003]. The challenge posed by the presence of such unqualified providers is enormous. It is not just because of the easy availability, but many women go to them to seek abortion because they trust these providers. For them, this option is reliable and 'safe'. Though some women are aware of few cases of complications resulting from these unqualified service providers, it has not warranted distrust for these local providers. Moreover, many women are ignorant that the services from these providers cost more than in hospital.

A woman coming to such 'medical' is easily guided as per the interest of the 'medical' owner, who in most cases is a paramedic or nursing professional, some in the government service too. More often than not, the woman is not referred to the listed service providing site (only the district hospital in Dhading's case) at first. Many are given unsafe and illegal service there. Usually where medicines are given for abortion by an unqualified provider and it remains unsuccessful, the woman is referred to hospital. In the process, the delay incurred might make the woman ineligible for safe abortion service. They are then bound to carry on with the pregnancy or are referred to some provider in city (usually Kathmandu) at unlisted site (though the provider might be government approved, such abortions beyond 12 weeks of gestation are provided in private clinics, which are unlisted). This can not be claimed a legal service, though it might be safe.

Though this study did not embrace an assessment of abortion services in the hospital, few issues regarding service delivery can be drawn from the perceptions shared by the respondents. Unlike many other government hospitals where abortion services are provided only on specified days [FHD/WHO/CREHPA 2006], Dhading hospital provides regular service. However, service is provided by the only doctor in the hospital. This sometimes leads to deferral of the service to a client, which can be hindering particularly for a woman coming from a distance. The cost has been brought down twice since the start of service in this hospital. For many women the cost in the hospital can be affordable. But for women for poorer sections, the fees could be detrimental to come for service. Despite the provision of exemption of fee for poor clients, the number of subsidy

given in last 7 months indicates that not many poor clients are benefiting. The level of exemptions is low probably because the cost is borne by the hospital itself without any compensation from the government. However, this issue and other issues of quality of care at the hospital need further assessment.

4.2 Recommendations

The factors that could hinder a woman from deciding, seeking and receiving safe termination of an unwanted pregnancy have just been discussed. There could be many solutions to the existing problems and barriers but it is not possible to tackle all at once. Many of the barriers can be well out of the reach and scope of the health system. Given below are few recommendations that need more attention for ensuring good access of safe abortion services, mainly for those living in remote hilly areas.

First and foremost barrier needed to be targeted is the lack of awareness. So main focus of raising awareness should be on:

- legal status of abortion,
- the availability of safe service – where, when, how much is the cost,
- safety net of 12 weeks gestation period – “earlier the better”, and
- basic knowledge reproductive health, including early signs of pregnancy.

In the light of one significant result that came in the survey, the knowledge of legal abortion seems to have an influence on having a positive attitude towards abortion rights of unmarried women. This further emphasizes the need for raising awareness. Several media and forums could be utilized for wider information dissemination. As evident from the study, radio is the most accessed medium. FCHV can be very effective in informing women in mothers’ group. Apart from the legal and service awareness, the issue of social stigma attached to abortion should also be addressed through structures and mechanisms of social mobilization, even outside the health system.

The distance barrier is not easily solved unless service is taken as close to the client as possible. In the present context, it is difficult to cater a doctor’s service in most remote

areas. So other ways of expanding services in the periphery should be sought. Training and authorizing mid-level provider like staff nurse is already under discussion at policy level [FHD/WHO/CREHPA 2006]. Such steps should be expedited. Use of medical abortion can also be considered once the surgical methods are well established. Medical abortion has the potential for use in rural setting, with appropriate health system support [Ganatra B and Johnston H 2002]. If option of medical abortions is adopted, other cadre of mid-level provider, like health assistants, could also be trained and authorized expanding the availability further. However, at present when such provisions are not there, emphasis must be given on strengthening the referral from peripheral health facilities.

Cost can be an important barrier for the poor. So, measures should be taken to regulate the price to a minimum possible level. At the same time, it is imperative to place strong policy and practice of fees exemption to encourage very poor to seek safe services. It would be better to have separate funds earmarked from the government or other sources to compensate for the subsidies given to poor clients. Though the service utilization pattern in the hospital is more or less similar to the distribution of castes in the district, it is somewhat lower in *dalit*, the lower caste groups. Any program on raising awareness on expanding access to this service should consider targeting this group specifically. Confidentiality and sensitivity on the part of the providers should also be ensured to encourage unmarried girls from accessing the service.

While different measures to strengthen utilization of safe services are very crucial, they are not likely to avoid large number of unsafe abortions provided by unqualified providers in the villages. Strong punitive measures are mandatory to discourage such practice. This could be done through law enforcing, social mobilization as well as public vigilance involving citizen groups and community based organizations.

Providing safe abortion is an option for unwanted pregnancy resulting from variety of reasons. However, as promulgated by ICPD, “in no case should abortion be promoted as a method of family planning” [United Nations 1995, paragraph 8.25]. Contraceptive

prevalence rate (CPR) of Dhading district is low at 31.0% and unmet need for contraceptives is high [DHO Dhading 2006]. In such context, efforts on increasing the use of contraceptives should be continuously strengthened.

4.3 Limitations

In this study, primarily purposive sampling was employed. So the findings are by no means intended to be generalized. They have to be taken as context specific and have to be interpreted as such. The survey also does not represent the study population, so the findings are more indicative, rather than representative.

All qualitative data in the study was collected by the researcher himself. Researcher being a male and a doctor might have influenced the responses. But care was taken to ensure the presence of a female research assistant in all discussions and interviews to make the respondents feel at ease and express freely. Introducing the researcher as a doctor was found helpful in making women comfortable to talk on the sensitive issue of abortion. Nevertheless, while introducing to the participants, stress was given on researcher being a student of a Master level course, and the research being a part of his studies.

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A. Guiding questions for FGD

Introduction

- Demographic questions – Name, Age, Education, Occupation
- Obstetric history – Number of pregnancy, live births, living children, abortion

Abortion

- What do you understand by abortion (*garbha-patan*)?
- What are other local terms used for abortion?
- How does society look at abortion?
- What is the religious belief about abortion?
- How common is abortion in this village?
- Where do women from this village usually go for abortion service?
- How much does it cost for abortion there?
- Can you tell me any case, you know or heard of, who had received abortion service in last 2 years?
- Is abortion legal in Nepal?
- How did you know it?
- Do you think women should have the right to have abortion if they want?
- Do you think unmarried girls should have the right to have abortion if they are pregnant?
- Have you heard of family planning methods?
- How common is the use of family planning in the village?
- Do you think people use abortion as a family planning method?
- What do you understand by safe and unsafe abortion?
- Do you know if safe abortion services are available in the district? Where?
- Where would you go if you wanted to have an abortion? Why?
- What should be done to ensure that the women from this village get the abortion service easily?

B. Guiding Questions for in-depth interview

Introduction

- Demographic questions – Name, Age, Education, Occupation
- Obstetric history – Number of pregnancy, live births, living children, abortion

Abortion

- What do you understand by abortion (*garbha-patan*)?
- What are other local terms used for abortion?
- How does society look at abortion?
- What is the religious belief about abortion?
- How common is abortion in this village?
- What are the common reasons in this village for women going for abortion?
- Is it common in any particular group of women?
- Where do women from this village usually go for abortion service?
- How much does it cost for abortion there?
- How is the service there?
- Have you heard of any case having complications due to abortion?
- Have you heard of any death due to abortion?
- Can you tell me any case, you know or heard of, who had received abortion service in last 2 years?
- Is abortion legal in Nepal?
- How did you know it?
- Abortion is legalized. Do you think it is good to liberalize abortion?
- Do you think women should have the right to have abortion if they want?
- Do you think unmarried girls should have the right to have abortion if they are pregnant?
- Who would a pregnant woman generally talk to if she did not want the baby?
- Do you think there is any change in the trend of child bearing (number of children a woman gives birth to)?
- How do you think this is happening?
- Have you heard of family planning methods?
- Are family planning methods (contraceptives) easily available in village?
- How common is the use of family planning in the village?
- Do you think people use abortion as a family planning method?
- Do you think abortion should be promoted instead of family planning?
- What do you understand by safe and unsafe abortion?
- Do you know if safe abortion services are available in the district? Where?
- How easy is it to get that service?
- Where do you think the services are unsafe?
- Why do you think women go there?
- Where would you go if you wanted to have an abortion? Why?
- What do you think a service providing facility should be like?
- What do you think a service provider should be like?
- What should be done to ensure that the women from this village get the abortion service easily?

KAP survey questionnaire (structured and closed-ended) with verbal consent form.

Knowledge, Attitude and Perception Survey Questionnaire

On

Legal and Safe Abortion Services in Nepal

RESEARCH COORDINATOR

Dr Amit Bhandari
MPH Student
James P Grant School of Public Health
BRAC University
Dhaka, Bangladesh

INTERVIEWER

ID No. ____

Initials: _____

Date of interview: ____ / ____ / ____ (dd/mm/yyyy)

Survey code number:

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Survey completed?

YES.....1

NO.....0

Reason for incomplete survey:

Refused to complete.....1

Postponed.....2

Respondent not at home.....3

Other (Specify) _____4

INAP.....77

Verbal Consent Statement

Hello, my name is _____ and I am a research assistant for Dr Amit Bhandari, who is currently doing this research as a part of his study at BRAC University, Bangladesh. He is conducting a survey with married women aged 15-49 years on issues related to abortions. The information gathered from this survey will be used for his study purpose and also for informing health stakeholders at district and central level. In this context, I would like to ask you 32 questions and it will take about 20 minutes. Any information that you give during this interview will be kept confidential and not disclosed to anyone outside the survey team. Your name and identity will not appear anywhere.

Your participation in this survey is voluntary. There is no intended risk or benefit for participating in this survey. I would appreciate if you answer all the questions but please remember that you are free to withdraw from the interview at any time or to refuse to answer any particular question that you feel uncomfortable with.

So do I have your consent to proceed with the interview?

YES ☐

NO ☐

SECTION A: SOCIO-DEMOGRAPHY**I will start with some general information about you and your household.**

1	<p>How old are you?</p> <p>____ years</p> <p>DK88</p> <p>NR99</p>
2	<p>What caste do you belong to?</p> <p>Brahmin/Chhetri1</p> <p>Newar.....2</p> <p>Rai/ Limbu3</p> <p>Magar/ Gurung/ Tamang/ Sherpa.....4</p> <p>Kami/ Damai/ Sarki.....5</p> <p>Chepeng.....6</p> <p>Others (Specify)7</p> <p>DK.....88</p> <p>NR.....99</p>
3	<p>What religion do you follow?</p> <p>Hindu.1</p> <p>Buddha.....2</p> <p>Islam3</p> <p>Christian.....4</p> <p>Others (Specify)5</p> <p>DK.....88</p> <p>NR.....99</p>
4	<p>What is the highest level of education you completed?</p> <p>None0</p> <p>Informal1</p> <p>Primary school (up to 5th grade)2</p> <p>Secondary school (up to 10th grade)3</p> <p>Higher secondary school (up to 12th grade)4</p> <p>College or higher.....5</p> <p>DK88</p> <p>NR.....99</p>

5 What is your main occupation?

Agriculture.....1
 Teaching2
 Government service3
 Business.....4
 Skilled labour.....5
 Unskilled labour.....6
 Studies.....7
 Housewife8
 Others (*Specify*)9
 DK88
 NR99

6 What is the highest level of education your husband completed?

None0
 Informal1
 Primary school (up to 5th grade)2
 Secondary school (up to 10th grade)3
 Higher secondary school (up to 12th grade)4
 College or higher.....5
 DK88
 NR.....99

7 What is your husband's main occupation?

None (Unemployed).....0
 Agriculture.....1
 Teaching2
 Government service3
 Business.....4
 Skilled labour.....5
 Unskilled labour.....6
 Studies.....7
 Others (*Specify*)8
 DK88
 NR99

SECTION B: FERTILITY

Now I will ask you some questions related to your pregnancies and child births.

8	Have you ever become pregnant? Yes.....1 No.....0 DK.....88 NR.....99	} SKIP to Question 12
9	How many times have you been pregnant so far? _____ INAP.....77 DK.....88 NR.....99	
10	How many sons and daughters have you given (live) birth to? Number of sons _____ Number of daughters _____ INAP.....77 NR.....99	
11	How many sons and daughters are alive now? Number of sons _____ Number of daughters _____ INAP.....77 NR.....99	

SECTION C: CONTRACEPTIVES

Now I will ask you some questions related to family planning method.

12 Have you ever heard of family planning method?

Yes.....	1	} SKIP to Question 16
No.....	0	
DK.....	88	
NR.....	99	

13 What are the methods you have heard?

(PROBE: Any others?)

	<u>Mentioned</u>	<u>Not mentioned</u>	<u>INAP</u>	<u>DK</u>	<u>NR</u>
Pills.....	1	0	77	88	99
Condom.....	1	0	77	88	99
Depo provera (DMPA Injection).....	1	0	77	88	99
Emergency contraception.....	1	0	77	88	99
Norplant.....	1	0	77	88	99
IUD/ Copper-T.....	1	0	77	88	99
Vasectomy.....	1	0	77	88	99
Tubectomy/Tubal ligation.....	1	0	77	88	99
Withdrawal method.....	1	0	77	88	99
Calendar method.....	1	0	77	88	99
Breast-feeding (Lactational amenorrhea). 1	0	77	88	99	
Others (Specify).....	1	0	77	88	99

14 Have you ever used a family planning method?

Yes.....	1	} SKIP to Question 16
No.....	0	
INAP.....	77	
DK.....	88	
NR.....	99	

15	What are the methods you have used? (PROBE: Any others?)				
		<u>Mentioned</u>	<u>Not mentioned</u>	<u>INAP</u>	<u>DK</u> <u>NR</u>
	Pills.....	1	0	77	88 99
	Condom.....	1	0	77	88 99
	Depo provera (DMPA Injection).....	1	0	77	88 99
	Emergency contraception.....	1	0	77	88 99
	Norplant.....	1	0	77	88 99
	IUD/ Copper-T.....	1	0	77	88 99
	Vasectomy.....	1	0	77	88 99
	Tubectomy/Tubal ligation.....	1	0	77	88 99
	Withdrawal method.....	1	0	77	88 99
	Calendar method.....	1	0	77	88 99
	Breast-feeding (Lactational amenorrhea). 1	0	77	88 99	
	Others (Specify).....	1	0	77	88 99

SECTION D: ABORTION

Now I will ask you some questions related to abortions.

16	Is abortion legal in Nepal?				
	Yes.....	1			
	No.....	0			
	DK.....	88			
	NR.....	99			

} SKIP to Question 20

17	Where did you learn that abortion is legal in our country? (PROBE: Any others?)				
		<u>Mentioned</u>	<u>Not mentioned</u>	<u>INAP</u>	<u>DK</u> <u>NR</u>
	Radio.....	1	0	77	88 99
	Television.....	1	0	77	88 99
	Newspaper/ Magazine.....	1	0	77	88 99
	Health worker.....	1	0	77	88 99
	FCHV/ TBA.....	1	0	77	88 99
	Chemist.....	1	0	77	88 99
	Poster/ Pamphlet/ Brochure.....	1	0	77	88 99
	NGO representatives.....	1	0	77	88 99
	Friends/ family/ acquaintances.....	1	0	77	88 99
	Others (Specify).....	1	0	77	88 99

18	<p>From what you have heard, what are the conditions under which abortion is legal in our country? (PROBE: Any others?)</p> <p>[Conditions not to be read out -</p> <p>Condition 1: Any reason up to 12 weeks of pregnancy</p> <p>Condition 2: Up to 18 weeks of pregnancy if pregnancy results from rape or incest</p> <p>Condition 3: Any time during pregnancy if the life of mother is at risk or if the fetus is deformed]</p> <table><tr><td></td><td><u>Mentioned</u></td><td><u>Not mentioned</u></td><td><u>INAP</u></td><td><u>DK</u></td><td><u>NR</u></td></tr><tr><td>Condition 1.....</td><td>1</td><td>0</td><td>77</td><td>88</td><td>99</td></tr><tr><td>Condition 2.....</td><td>1</td><td>0</td><td>77</td><td>88</td><td>99</td></tr><tr><td>Condition 3.....</td><td>1</td><td>0</td><td>77</td><td>88</td><td>99</td></tr></table>		<u>Mentioned</u>	<u>Not mentioned</u>	<u>INAP</u>	<u>DK</u>	<u>NR</u>	Condition 1.....	1	0	77	88	99	Condition 2.....	1	0	77	88	99	Condition 3.....	1	0	77	88	99
	<u>Mentioned</u>	<u>Not mentioned</u>	<u>INAP</u>	<u>DK</u>	<u>NR</u>																				
Condition 1.....	1	0	77	88	99																				
Condition 2.....	1	0	77	88	99																				
Condition 3.....	1	0	77	88	99																				
19	<p>From what you have heard, what are the conditions under which abortion is illegal in our country? (PROBE: Any others?)</p> <p>[Conditions not to be read out -</p> <p>Condition 1: If done without the consent of pregnant women</p> <p>Condition 2: If done on basis of sex determination</p> <p>Condition 3: If done beyond the condition and/or duration stated by law]</p> <table><tr><td></td><td><u>Mentioned</u></td><td><u>Not mentioned</u></td><td><u>INAP</u></td><td><u>DK</u></td><td><u>NR</u></td></tr><tr><td>Condition 1.....</td><td>1</td><td>0</td><td>77</td><td>88</td><td>99</td></tr><tr><td>Condition 2.....</td><td>1</td><td>0</td><td>77</td><td>88</td><td>99</td></tr><tr><td>Condition 3.....</td><td>1</td><td>0</td><td>77</td><td>88</td><td>99</td></tr></table>		<u>Mentioned</u>	<u>Not mentioned</u>	<u>INAP</u>	<u>DK</u>	<u>NR</u>	Condition 1.....	1	0	77	88	99	Condition 2.....	1	0	77	88	99	Condition 3.....	1	0	77	88	99
	<u>Mentioned</u>	<u>Not mentioned</u>	<u>INAP</u>	<u>DK</u>	<u>NR</u>																				
Condition 1.....	1	0	77	88	99																				
Condition 2.....	1	0	77	88	99																				
Condition 3.....	1	0	77	88	99																				
20	<p>Do you think a woman should have the right to have an abortion?</p> <p>Yes.....1</p> <p>No.....0</p> <p>DK.....88</p> <p>NR.....99</p>																								
21	<p>Do you think an unmarried girl should have the right to have an abortion?</p> <p>Yes.....1</p> <p>No.....0</p> <p>DK.....88</p> <p>NR.....99</p>																								

22	<p>From what you know, how common is abortion in this village? Is it...</p> <p>common,1</p> <p>less common, or2</p> <p>rare?3</p> <p>DK.....88</p> <p>NR99</p>																
23	<p>In general, where would the women of this village go first if they wanted to have an abortion?</p> <p>District Hospital.....1</p> <p>NGO/private hospital / clinic (<i>Specify</i>)2</p> <p>Doctor's private clinic.....3</p> <p>Medical shop.....4</p> <p>Paramedics.....5</p> <p>TBA.....6</p> <p>Outside the district (<i>Specify</i>)7</p> <p>Others (<i>Specify</i>)8</p> <p>DK.....88</p> <p>NR.....99</p>																
24	<p>Is there any facility in this district where safe abortion services are provided?</p> <p>Yes.....1</p> <p>No.....0</p> <p>DK.....88</p> <p>NR.....99</p> <p>} SKIP to Question 26</p>																
25	<p>In which facilities are safe abortion services provided?</p> <table border="1"> <thead> <tr> <th></th> <th><u>Mentioned</u></th> <th><u>Not mentioned</u></th> <th><u>INAP</u></th> <th><u>DK</u></th> <th><u>NR</u></th> </tr> </thead> <tbody> <tr> <td>District Hospital.....1</td> <td>0</td> <td>77</td> <td>88</td> <td>99</td> </tr> <tr> <td>Others (<i>Specify</i>)1</td> <td>0</td> <td>77</td> <td>88</td> <td>99</td> </tr> </tbody> </table>		<u>Mentioned</u>	<u>Not mentioned</u>	<u>INAP</u>	<u>DK</u>	<u>NR</u>	District Hospital.....1	0	77	88	99	Others (<i>Specify</i>)1	0	77	88	99
	<u>Mentioned</u>	<u>Not mentioned</u>	<u>INAP</u>	<u>DK</u>	<u>NR</u>												
District Hospital.....1	0	77	88	99													
Others (<i>Specify</i>)1	0	77	88	99													
26	<p>Have you ever wanted to terminate a pregnancy but did not?</p> <p>Yes.....1</p> <p>No.....0</p> <p>DK.....88</p> <p>NR.....99</p> <p>} SKIP to Question 28</p>																

27	What was the main reason you did not terminate the pregnancy?					
	<div data-bbox="354 136 1136 766"> <p>Did not know where to go.....1</p> <p>Husband did not agree.....2</p> <p>In-laws did not agree.....3</p> <p>It was too costly.....4</p> <p>Scared of procedures.....5</p> <p>Previous bad experience.....6</p> <p>Bad experience of friend / family7</p> <p>Afraid of family or social reaction.....8</p> <p>Consider abortion as a sin.....9</p> <p>Others (Specify)10</p> <p>INAP.....77</p> <p>DK.....88</p> <p>NR.....99</p> </div>					
28	Have you ever had an abortion done?					
	<div data-bbox="354 924 1437 1113"> <table> <tr> <td>Yes.....1</td> <td rowspan="4">} SKIP to Question 32</td> </tr> <tr> <td>No.....0</td> </tr> <tr> <td>DK.....88</td> </tr> <tr> <td>NR.....99</td> </tr> </table> </div>	Yes.....1	} SKIP to Question 32	No.....0	DK.....88	NR.....99
Yes.....1	} SKIP to Question 32					
No.....0						
DK.....88						
NR.....99						
29	What was the main reason for having the abortion done?					
	<p data-bbox="251 1270 1421 1312"><i>(CONSIDER only the last episode, if the respondent has had more than one abortion done.)</i></p> <div data-bbox="354 1365 1136 1942"> <p>I was unmarried then.....1</p> <p>Pregnancy affected my study.....2</p> <p>Had too many children.....3</p> <p>Could not afford to have that child.....4</p> <p>Wanted to wait a few more years.....5</p> <p>It was a girl child.....6</p> <p>Pregnancy endangered my health.....7</p> <p>Fetus had serious abnormality.....8</p> <p>Others (Specify)9</p> <p>INAP.....77</p> <p>DK.....88</p> <p>NR.....99</p> </div>					

30 Where did you first go to have an abortion?
(CONSIDER only the last episode, if the respondent has had more than one abortion done.)

District Hospital.....1
 NGO/private hospital / clinic (Specify)2
 Doctor's private clinic.....3
 Medical shop.....4
 Paramedics.....5
 TBA.....6
 Outside the district (Specify)7
 Others (Specify)8
 INAP.....77
 DK.....88
 NR.....99

31 Who first suggested or advised you to go there?

No one.....0
 Husband.....1
 Parent/ Sibling2
 In-law3
 Friend/ Neighbour.....4
 TBA.....5
 Health worker/ FCHV6
 Chemist.....7
 Others (Specify)8
 INAP.....77
 DK.....88
 NR.....99

At the end, let me ask you your opinion related to abortion services.

32 For abortion services, women should go only to government approved hospital or clinic. Do you...

Strongly support,1
 Somewhat support,2
 Somewhat oppose, or.....3
 Strongly oppose?4
 DK8
 NR.....9

Thank you very much for participating in this survey.